			1 - For State Registrar	State of Marylai	nd / Depa		ealth and	Mental Hygi	ene	5 1700	0.1
			Hegistrar     Decedent's Name (First, Middle, Las	†)		tineate of L	Jean	2. Date of Death	g. No U U	3. Time of De	eath
	Physici	an	FLORENCE	T A	aNOL	i))		Month	Day Y	ear / - 22	
	/Medic		4a. Facility Name (If not institution, give		•	4b. City, Town, or	Logation of Dog	may	4c. County of	0.3	P
	Examin	er	2822 Florida Ave	street and number)							
			5. Social Security Number 6. Se	7. Age (In yrs	last hirthday)	Baltimor	If Under 24 Hr		Baltimo		- ionias
	Funeral			M 2⊠F 81	Yrs.	Months Days	Hours Mir		Year)	. Birthplace (State or F Country) Maryland	oreign
	Director		Usual Residence of Decedent	01				J 2 1J2		riar y rand	
	ow ow	1	10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City I	Limits
	Man,	to	MD Baltimo	ore	Baltim	ore Highl	ands			1 🗆 Yes 2	<b>™</b> No
	1 the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	at Country?	
	3a o	0	2822 Florida Ave			21227		1	United S	tates	
	death ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in t	J.S. 13.	Was Decedent of His	spanic Origin? (		14. Race -	American fndian,	
9	after or ite	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☒ No				no Hican, etc.)		White, etc.	
8	within 72 hours after death with the Maryland ene. than 'netural', or items 23a or 28a-f show Ita Madical Examinar must be notified at	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify:	White	
20	72 hc	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual Occupa kind of work done d DO NOT use retired;	ition	orking 1	6b. Kind of Busi	ness/Industry	
2	within ene. than "	nple	Elementary/Secondary (0-12)	College (1-4or 5+)				, and a			
21	Hygien Hygien other th	Cor	12		Medi	ical Secre			Health (	Care	
p	be filed tal Hygid of other event, II	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle, M	laiden Sumame)		
Vla	should I	2	Michael Edward P	arker			Teres	a Kerr			
Maryland 21215-0036	0 0 0 0		19a. Informant's Name/Relationship (7					Rural Route Number,			1 0 0 7
	1 and 2 Health em 27 Ither tr	1 2	Diane Riggan / da							Maryland 2	.1227
ore	of Horizon		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Pernoval from State	Place of Dispo cemetery, crei	sition (Name of matory or other place	9)	Date 2	0c. Location - Ci	ty or Town, State	
Ē	Pag nent ent: I		`4 □ Donation 5 □ Other (Specify		* C	Crématory				re, Marylar	
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		21. Signature of Funer Fervice Licens	1.010						me of Lanso	
<b>m</b>	89 = 9		JULY FINE	Klibik	2	719 Hammon	nds Feri	cy Rd Lans	downe, 1	Maryland 21	L227
,092	/Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, I ary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse  Due to (or as a conse  Due to (or as a conse	(uance of):	tre hear		seme			
P.O. Box 6876	it the death certificate by the at encing phy: tached for use as the	Physician/Medical	IF FEMALE: 23b: Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	d	aldeath 3□	Ectopic pregnancy			23d. Date of Month	,	ar
	res tha igned be de	by F	Part II. Dther significant conditions co	0		nderlying cause give	n in Part I.	23e. Did tob	acco use contrib	ute to the cause of dear	th?
Records,	w require been sig should t			ung Ca	icer			1 <b>1 1 1 1 1 1 1 1 1 1</b>	s 2 □ No 3	☐ Probably 4 ☐Unk	nown
900	e law re has be je 2 sho	ompleted		O				24a. Was an autopsy	24b. We	re autopsy findings ava or to completion of caus	ailable
m	The I	ШО						perform	ed? dea	ith? IYes 2 <b>X</b> 0No	
Vital	ician: Tentifical	3e C	25. Was case referred to medical				26. Place of De	eath (Check only one			
/ \	8 5	To B	examiner?	Hospital: 1 Inpatient 2	ER/Outpatier	at 3 DOA Othe	or: 4 ☐ Nursing	Home 5 Neside	nce 6 Other	(Specify)	T I
Jof	ding Phy h. After thi funeral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		at	28d. Describe how			
0	Attending r death. ector: After by the fune	atlc	1 Accident 5 Pending Investigation				res 2□No				
Division	ar de recto	ertification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At I	nome, farm, str	eet, factory, office		28f. Location (Str. City or Town,		or Rural Route Number	ſ,
Ö	s afte	Cert		building, etc. (opec.	• • • • • • • • • • • • • • • • • • • •			J. J	Olaley		
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) 1 Medical Exam	ysician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, deatl ation and/or in	n occurred at the tim vestigation, in my op	e, date and place inion, death occ	e, and due to the ca curred at the time, da	use(s) and mann te and place, and	er as stated. d due to the cause(s)	
	To the within 2. To the complete	×	29b. Signature and title of certifier	)		29c. License				Month, Day, Year)	
			> Then !!	um w	)	1	14713	7	MOH.	19,200	5
	4		30. Name and address of person who co	completed cause of death (Ite	m 23a) (Type,	Print) CUCUS NO	Suite	200, 61.	WBW	19,200, WIEIMD2/	061
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 0 2005		ature						

DHMH 17 Rev 1/2001

-336	9	·	1- State of Maryland / Dep 1- State Unpend Item 23a,27,28a-f per me	artment of Health and M 0843 5-25-05 tas ortificate of Death	fental Hygien	2005 17002
	Physici		1. Decedent's Name (First, Middle, Last)  ACO.		2. Date of Death	2005 Year 3. Time of Death
	/Medio		4a. Facility Name (If not institution, give street and number) 3416 Dunran Road	4b. City, Town, or Location of Death Dundalk	4	4c. County of Death Baltimore County
9	Funeral Director		5. Social Security Number  6. Sex 100 M 2 F 7. Age (In yrs. last birthday 100 M 2 F N A. Yrs.		8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign
(V)	aryland show	٦.	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	vith the Maryland t or 28a-1 show be notified at	Director	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Country?
"	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "netural", or items 23s or 28s-f show event, It s Medical Examiner must be notified at	Funeral	1 Never Married 2 Married 1 Yes 2 1 No	Was Decedent of Hispanic Origin? (Spell Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	72 hours af	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:  15. Decedent's Education 16a. Deci	1 ☐ Yes 2ᢂNo Specify:	16b.	Specify: White
2121	ad within 72 ho giene. er then "netu i, ir e Medical	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  For K	e kind of work done during most of worki DO NOT use retired) Lift Operator	- U	chrehouse
Maryland	s 1 and 2 should be filed with f Health and Mental Hygiene. item 27 is marked other ther other treumatic event, ILE N	To Be	17. Father's Name (First, Middle, Last) Frank Joseph Ace, SR	18. Mother's Name Myr + 14	e (First, Middle, Maide	en Sumame)
	1 and 2 shu Health and iom 27 is m		William Ace - Drother 260	ling Address (Street and Number or Rura	PALTIM.	are MO 21219
altimore,	0 0		*4 Donation 5 Other (Specify)	ne LG (Chapel-BelAir 5		Drest Hill MD
Ball	permit. Pag Department Importent: I any Injury o		Kimberly V. Switcher Pr	ACEFUL ALTERNAT	IVESFUNER	M MO 2:09 3 RALACREMATION CENTER
	Physician		23a. Part1. Enter the disease, of complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Acetaminophen And	nter the mode of dying, such as cardiac of Diphenhydramine I		Approximate Interval Between Onset and Death
	/Medical Examiner	_	Due to (or as a consequence of):  Sequentially list conditions.			
	be executed sician and burial-transit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):			
38760,	cate phy the	dicai	d			
P.O. Box 6	Attending Physicien: The law requires that the death certific ridath. r death. ector: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	w requires that been signed b should be dete	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death?  2 No 3 Probably 4 Wunknown
of Vital Records,	The law re cate has been page 2 sho	Completed			24a. Was an autopsy performed?	
of Vita	Physicien: T this certificat al director, pa	To Be	25. Was case referred to medical examiner?  **TXYes** 2 \( \) No	ent 3 DOA Other: 4 Nursing Ho		₩Xother (Specify) at scene
Division	Mending Ph death. ctor: After thi y the funeral	ertification:	27. Manner of Death  1 Natural 5 Pending investigation  2 Accident investigation  3 X Suicide 6 Could not be	A <sup>M</sup> Work? 1 □ Yes X No S	ubject ing	gested pills
Div	urs afte	O	28e. Place of Injury - At home, farm, s building, etc. (Specify)  Scene  29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea		Dundalk, N	
	To the Hospitel or within 24 hours after To the Funerel Direction completely filled in the filled in	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or i and manner stated.  29b. Signature and title of certifier	nvestigation, in my opinion, death occurr  29c. License number	red at the time, date a	and place, and due to the cause(s)  Date signed (Month, Day, Year)
	P > P 0		30. Name and address of passen who completed cause of death (Hom 22a) (Tues	OCME	Ma	y 16, 2005
	Sta	te	30. Name and address of person who completed cause of death (Item 23a) (Type ANA WB (O, MD)  31. Date filed (Month, Day, Year)		Baltimore,	Maryland 21201
	Registr	- 1	MAY 2 0 2005 Seede &	the state of the s		

	1 - Sta	rite gistrar	St	ate of M		d / Depa		of H	ealth a		ental Hy	giene	005	17003
Dhysisian	1. Dece	dent's Name (First, Midd									2. Date of Dea	Day	Year	3. Time of Death
Physician /Medical		nda Anasta									May	18,	2005	6:40 P M
Examiner		lity Name (If not institution Lchrist Cen		t and numbe	r)		4b. City, T	own, or		f Death		4c. C	ounty of Death Baltim	
Gurranal		Security Number	6. Sex	7. 4	ige (In yrs. I	ast birthday)	If Under 1	Year	If Under	24 Hrs.	8. Date of Birt (Month, Da	h		place (State or Foreign intry)
Funeral Director	1	3-01-0636	1 □ M	21 <b>X</b> F	86	Yrs.	Months	Days	Hours	Min.	July 9	, Year) , 191	8 Mari	yland
P 2	Usual F	desidence of Decedent	· · · · · · · · · · · · · · · · · · ·		10c City	, Town or Lo	cation							10d. Inside City Limits
Aaryla 1 show			, timore		Too. On		kvill	0						1 Yes 2 No
with the Maryland a or 28e-f show the notified at	10e. St	yland Bal	- Canonie			100	10f. Zip (					10g. Citize	en of What Cou	
Suffer death with the Marylan tritems 23s or 28e-1 show river rest to notified at Funeral Director	88	00 Walther	Blud.,	Condo	4604			212	34				U.S.A	•
Je E B	11. Ma	ital Status	12. V	Vas Deceder	t Ever in U.	S. 13.	Was Decede	ent of His	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	- 14	Race - Amer Black, White	
J36 urs afte of, or it	1	Never Married 2 ☐ Ma Widowed 4 ☐ Divorce		☐Yes 21 Yes, Give		1	1 □ Yes 2,						pecify: W	hite
15-0036  "naturel", or ite	34		nt's Educatio	ear or Dates		16a. Dece	dent's Usual	Occupa	ition			16b. Kind	d of Business/li	
21215-00 ed within 72 hou ygiene. ner then "nature it, the Medical E	Flen	(Specify only high entary/Secondary (0-12)	est grade cor	n <i>pleted)</i> College (1-4o	r 5+)	(Give life.	kind of work DO NOT use	k done d e retired)	luring mos	t of workin	ig .			·
be filed within 7 tal Hygiene. In ovent, the Med Be Comple	12	th Grade				Нс	memak	er					Own Ho	me
be file be file other overlines.	17. Fat	ner's Name <i>(First, Middle</i> an Grudz									(First, Middle,		umame) LYCZKOW	shi
Maryland 21215-0036 at 2 should be filed within 72 hours aft and Mental Hygiene. 27 is marked other then "naturel", or treumatic event, the Medical Exert To Be Completed by F		formant's Name/Relation		Print)		19h Mailir	na Address	(Street a					Town, State, Zi	
re, Maryla s 1 and 2 should f Health and Mer item 27 is marke other treumatic		rnard G. Ba			on)		•	•			insvill			
ore, M	Į.	ethod of Disposition				lace of Dispo emetery, crer	sition (Name	e of her place	a)	D	ate	20c. Loca	ation - City or T	Town, State
Page Page Int: If Int: If		XBurial 2 □ Cremation □Donation 5 □ Other (		val from Sta						5/23/	2005	Crown	sville,	, Maryland
Baltimore, permit Pages 1 at Department of Hea Important: If ten any Injury or other	21. Sig	Bucin C		nel							munek utimon		al Home	es 236
100	23a. F	art1. Enter the disease, hock, or heart failure. Lis	or complications to only one ca	use on each	line.									Approximate Interval Between Onset and Death
Physician -	diseas	liate Cause (Final e or condition ng in death)	a	end	- itra	ge o	65 tr	ctu	ne (	uny	dise	かづて		Jears
/Medical Examiner	163010	ig in death)		Due to (or a	as a conseq	uence of):								~
<u> </u>	Seque if any,	ntially list conditions, leading to immediate Enter Underlying (Disease or injury	b	Due to (or a	as a conseq	uence of):								
executed in and ial-transit	Cause Cause that in	tiated events												
		ng in death) Last		Due to (or a	as a conseq	uence of):								
S S S			d	<del></del> -										
<b>2</b>	IF FE		23c.	f yes, outcon	ne of pregna	incv						25	3d. Date of deli	van
Box leath cert attendin for use	23b. V	the past 12 months?  ☐ Yes 2 No		1 ☐Live birth 4 ☐ Pregnant	2 Feta	I death 3[	Ectopic pre Other (spe					2	Month	Day Year
by the datached	9	Unknown		9 Unknown							-			
IS, P	rant II.	Other significant condi		- 1			nderlying ca	ause give	en in Part I					the cause of death?
Records, he law requires t e has been signe age 2 should be		commy	17740	ng a	( Sept.	1-6					10	Yes 2 🔀	No 3∐Pro	obably 4 ∐Unknown
Il Record  The law requir  Tate has been si page 2 should  Completed			3	<u>/</u>							24a. Was		24b. Were autoprior to co	topsy findings available completion of cause of
Vital Relicion: The licion: The lectrificate harden, page											1 Tes	2 No	1 Tes	
f Vital ysicien: Ti sis certificate director, pa	25. W	is case referred to medic aminer? ] Yes 2 <b>%</b> No	Hosp	ital: 1 🗆 Inni	ationt 2	ER/Outpaties	3 3 00	A Othe	ar.		n <i>(Check only o</i> me 5 ☐ Resi	-	Hother (See	(fy) Hospice
g Physi g Physi er this o eral dire		nner of Death	2	8a. Date of I		28b. Time o		Bc. Injury Work			28d. Describe			my Hospice
Division C teef or Attending P rs after death. el Director: After t led in by the funera Certification:	1) 2(		tigation	(WORLI,	Jay 1 tal)	Injury	М		Yes 2	No				
Divisio	3 4	]Suicide 6 □Coul □Homicide dete	d not be mined 2	8e. Place of building,	Injury - At he etc. (Specif	ome, farm, st	reet, factory,	, office		2	28f. Location ( City or To	Street and wn, State)	Number or Ru	ral Route Number,
Doltel of or														
Divisic  To the Hospitel or Attent within 24 hours after death within 24 hours after death completely filled in by the Medical Certificat	29a. (	tertifier 1 Certify Check only 2 Medic	al Examiner:	on: To the be On the basis and manner	of examina	owledge, deat tion and/or in	n occurred a vestigation,	in my op	ne, date ar pinion, dea	nd place, a ath occurre	and due to the ed at the time,	date and p	and manner as place, and due	stated. to the cause(s)
To the within To the comple		ignature and title of certif	ier	1.7					e number	ALCONO.			signed (Month	
		Il that	hung 1	rly	, un	D	1	101	(30.					2005
13	30. Na	me and address of perso	on who comp	leted cause of	of death (Iter	п 23а) (Туре,	Print)						les Str	eet
State	31. Da	te filed (Month, Day, Yea	ar)	32. <b>28</b> a	strar's Signa	ature		-		T	owson,	MD_2	1204	
Registrar			0 200	Dea	we .	BA	The state of	)						

Dandelie, Wanda 5-18-05 6:40 Pm. Deonte Brown 05-3406 AKG

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3406		1 - For State Registrar	State of Maryland	Department of Certificate			iene 200	5 17004
Physic /Med		1. Decedent's Name (First, Middle, Last)	ONTE	BRI	WN	2. Date of Dea Month May 16,	th Day Yea 2005	3. Time of Death 10:40 P M
Exam	iner	4a. Facility Name (If not institution, give  Johns Hopkins Host 5. Social Security Number 6. Se	oital	Baltin			4c. County of De	Birthplace (State or Foreign
Directo		Usual Residence of Decedent		Yrs.		12.4	· 1983 M	10d. Inside City Limits
e Marylar 8e-f show	ctor	MD 10a. State 10b. County		AUTIMON			10 Civil and Miles	1 Ves 2 No
th with th	Funeral Director	2702 OVERL	AND AVE.	10f. Zip C	21214		10g. Citizen of What	·A.
13-0030 72 hours after death with the Maryland "natural", or Items 23a or 28e-f show digal Examinan the notified an	b	11. Marita Status  1 D Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	13. Was Deceder If Yes, specify	t of Hispanic Origin? ( Caban, Mexican, Puel No Specify:	Specify Yes or No- nto Rican, etc.)	14. Race - Al Black, W Specify:	merican Indian, hyle, etc. DLACK
d within 72 hagiene.	Completed	15. Decedent's Edu (Specify only highest grad ElementarySectodary (0-12)		life. DO NOT use	mployE	D		nployED
yidilu ould be file Mental Hy arked othe	To Be (	17. Father's Name (First, Middle, Last)	BROWN		$\mathcal{D}$		BLANA	
Mand 2 sh and 2 sh lealth and m 27 is m her traum		19a. Informant's Name/Relationship (T)  ANTOINE OLE	(UNCLE)	19b. Mailing Address (\$2702 Over of Disposition (Name)	ERLAND	A . //	ATT, MC 20c. Location - City	21214
Dairimore permit. Pages 1 Department of H Importent: If ite any injury or ot		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licens	com	etany cramatory or other	ATH 5.	21.05 Avath C	BALTIMORE GREEN	EF, MARYLAND EFUNERAL HI JARY LAND 2121
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ligations that caused the death. ne cause on each line.	Do not enter the mode				Approximate Interval Between Onset and Death
Physiciar /Medica Examine	al.	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequent		MOUNDS			
be executed ician and burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence.  Due to (or as a consequence.					
death certific e attending ped for use as in	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnanc 1□Live birth 2 □Fetal d 4□Pregnant at time of dea 9□ Unknown	eath 3 Ectopic pres			23d. Date of Month	delivery Day Year
- 2 pg	þ	Part II. Other significant conditions or	ontributing to death but not resulti	ing in the underlying cau	ise given in Part I.	23e. Did to	h.e	e to the cause of death?  Probably 4 Unknown
The ate h	Completed					24a. Was autor perio 1 Yes	prior prior deat	a autopsy findings available to completion of cause of h? ¥es 2 □ No
of Vital Physician: This certifica	B	25. Was case referred to medical examiner?	Hospital:		Other	eath (Check only o		7
Ph. Ph.	-	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	8b. Time of Injury M	4 □ Nursing c. Injury at Work? 1 □ Yes 2 ☑ No	-	dence 6 Other (S	(HOT
OIVISIO or Attendate deatl after deatl Director: in by the	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Alemicide determined				City or Tox	Street and Number o.	r Rural Route Number, ,BALTINGRE, MD
To the Hospitel within 24 hours a To the Funeral I completely filled	edical (	(Check only 2 Medicel Exam	ysician: To the best of my knowl liner: On the basis of examination	edge, death occurred a in and/or investigation,	the time, date and pla n my opinion, death oc	ce, and due to the curred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
o the vithin 2 o the complet	Med	29b. Signature and title of certifier	and manner stated.	29c.	License number		29d. Date signed (M	fonth, Day, Year)
F S F Ö		> aness			OCME		May 17, 20	005
	5		10, MD	111	Penn Stree	et Baltim	ore Maryla	and 21201
Regi	State strar	31. Date filed (Month, Day, Year) MAY 2 0 28	32. Fegistrar's Signatu	4. Sparke				

DHMH 17 Rev 1/2001

Registrar

MAY 2 0 2005

Molera

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 19b per fh 2844 6-10-05 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Brimhall Pauline N 12:15P M May 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 12-10-1912 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
\_\_\_\_\_ Months Days Hours 1 □ M 2 🖸 F 479-36-7495 Yrs. 92 Iowa Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3160 Gracefiëld Rd Rm 1534 20904 USA 12. Was Decedent Ever in U.S. Armed Forces?

₽₹█\$\text{\$\text{P}\$\text{\$\text{\$Y}\$}\text{\$\e Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 Marned 1 ☐ Yes ŽINo Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Nurse Goverment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Howard Brimhall Jr. Blanche Boggess 131 24 ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gertrude Couch (POA) 3724 Gracefield Rd. Apt 201 Silver Spring MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
`4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 05-17-2005 Beltsville 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M00382 Rapp Funeral & Cremation Services 933 Cist Ave Silver Spring MD 20910

**Physician** /Medical Examiner

and Il-transit

sician a burial-

been signed by the should be detached

To the Hospitel or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records. P.O. Box 68760.

**Physician** 

/Medical

Examiner

Director

Be Completed by Funeral

2

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, it a Modical Exeminer man be notified at once.

Baltimore, Maryland 21215-0036

	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do not enter one cause on each line.	r the mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition resulting in death)	a Alzheimer's	disease			Onset and Death
		Due to (or as a consequence of):				
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Stroke  Due to (or as a consequence of):				
icai Exan	that initiated events resulting in death) Last	c				
Completed by Physician/Medicai Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)		23d. Date of deliv Month	rery Day Year
ed by Pr	Part II. Other significant conditions of	contributing to death but not resulting in the und	derlying cause given in Part I.			the cause of death? bably 4 Unknown
Complet				24a. Was an autopsy performed?	prior to co death?	opsy findings available ompletion of cause of
Be	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)		
2	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 ☐ Hursing Hom	ne 5 🗌 Resid <i>e</i> nce	6 ☐Other (Special	ify)
ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		28c. Injury at Work? M 1   Yes 2   No	8d. Describe how inju	ury occurred	
Certific	3 Suicide 6 Could not b 4 Homicide determined		et, factory, office 2	8f. Location (Street a City or Town, Stat	and Number or Rui te)	al Route Number,
edical Certification:	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exer	nysician: To the best of my knowledge, death niner: On the basis of examination and/or inve and manner stated.	occurred at the time, date and place, a estigation, in my opinion, death occurre	nd due to the cause( d at the time, date an	s) and manner as nd place, and due	stated. to the cause(s)
Ž	29b. Signature and title of certifier	Thumang HD	29c. License number D 5952 IL	29d. D.	ate signed (Month)	Day, Year)

SILVER SPRING, HD 20904

DHMH 17 Rev 1/2001

State Registrar

within 24 hours after death.

To the Funerel Director: A
completely filled in by the fu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOVERN J. PUTHUMANA 3110 GRACEFIELD ROAD

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 105 4a. Facility Name (If not institution, give street and number) 05 5 /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salare Dursino If Under 1 Year 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Yrs. Director 48 11/17/1956 MD 219-62-2765 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examinar must be netified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside Çity Limits 1 Nes 2 No Director MD Baltimore City Baltimore 10f. Zip Code 10g. Citizen of What Country? Funeral 1217 W. Fayette
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 21223 United States
14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: ð Specify: 3 ☐ Widowed 4 ☐ Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Masonry Brick Layer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ William H. Biggs Doris Lee Jean Mullenix 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cametery, crematory or other place)

Baltimore, MD 21216

20c. Location Cristal Lee Biggs 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State May 21 4 ☐ Donation 5 ☐ Other (Specify) Chosapeake Crematory Inc. 2005
22. Name and Address of Facility Beltsville, Maryland 21. Signature of Funeral Service Licensee M0986 Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (er as a consequence of) Examiner Hospital or Attending Physicien: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in lated events. Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ettending physician for use as the burie Physiclan/Medical Due to for as a consequence of resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Endocardita ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed s certificate has the director, page 2 s 2 1 No 1 Tes 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 👿 No Director: After this d in by the funeral di 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 DNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital
within 24 hours e
To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) od cause of death (Item 23a) (Type, Print) State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 2:35 A M 2005 DYERL May 5, 4c. County of Death 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Catonsville | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | TAN. 6, 1923 Baltimore Frederick Villa Nursing Home Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1 M 2 TF 82 Maryland 216-12-6458 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Relay Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21227 USA 5125 S. Rolling Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanislaus J. Filar Kazimiera Kiamut 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5125 S. Rolling Road, Relay, MD Marsha Byerly - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 5/19/2005 St. Augustines Cem. Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer I Lendce Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 17250 Washington Blvd., Elkridge, MD 21075 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the dis-shock, or heart faily Immediate Cause (Final FAILURE TO THRIVE Due to (or as a consequence of): FAILUNG LIVER Due to (or as a consequence of): CIRRITOSIC iver Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year 4 Pregnant at time of death 5 Other (specify)

3 ☐ Probably ←

1 ☐ Yes 2 ☐ No

16/05

24b. Were autopsy findings available prior to completion of cause of death?

Physician /Medical **Examiner** 

The law requires that the death certificate be executed

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certificate

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Box 68760,

Records, P.O.

Division of Vital

To the Hospitel or Attending Physicien:

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permit. Pages 1 Department of H Importent: If ite any injury or ot once.

**Physician** 

/Medical

**Examiner** 

10a. State

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**Funeral** 

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f Health and Mental Hygiene. Item 27 is marked other than "neturel", or Itams 23a or 28a-f show other treumatic event, it is Mouteal Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Examiner burial-transit Completed by Physician/Medical use jo detached Be 10 ical Certification: I Director: A

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23h Was decedent pregnant in the past 12 months? 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No autopsy 26. Place of Death Check onl one 25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗌 No investigation 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide Descripting Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

30. Name and address

29b. Signature and title of certifier

of person who completed cause of death (Item 23a) (Txpe, Print)
Fryendez MD YOS Fredericu Rd Steibz Catonsylle 32. Registrar's Signature

DHMH 17 Rev 1/2001

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		1	For State Registrar	State of	*	epartment of F Certificate of			giene 2005	17008
			1. Decedent's Name (First, Middle	Last)				2. Date of Dea	ath Day Year	3. Time of Death
	Physicia /Medic		Ellamay		В	ernhardt			9, 2005	4:30 P M
	Examin		a. Facility Name (If not institution,	-		4b. City, Town, o		Death	4c. County of Dea	ath
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	Funeral	:	5. Social Security Number	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. last birtl 88 Y	Months Days		Min. (Month, Da)	y, Year)	rthplace (State or Foreign Country) VA
١,,	Director	-	213-03-6655		00			April 3	0, 1917	VA
puel	MOM NOW		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
To N	a-f sh	ţō	MD N/	'A	Balt	imore				1X Yes 2 □ No
t d	or 28,	lred	10e. Street and Number		3	10f. Zip Code			10g. Citizen of What C	Country?
broth with the Mendend	23a (	al	279 South Robin			21224			USA	
2	s 1 and 2 should be little waryang the agent with the maryan the Health and Mental Hygiene. If Health and Mental Hygiene. If the stream state of the fraction of thems 23s or 28s-f show them 21s or 28s-f show other traumatic event, If a Modical Examinal reast to notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marri 3 ☒Widowed 4 □ Divorced	Armed For	е	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☒ No	an, Mexican, P	i? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - Am Black, Wh Specify: W	ite, etc.
် က်	within 72 ho ene. than "nature re Medicel E	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed)  College (1	-4or 5+)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of d)	f working	16b. Kind of Busines	
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Z	2 should be 1 and Mental b is marked of raumatic eve	ဥ	19a. Informant's Name/Relationsl	nip (Type, Print)	19b.	Mailing Address (Stree				Zip Code)
	and 2 s lealth ar m 27 is her trau		Darryl J. Welsh	n sc	on 74	27 School A	Avenue,	Dundalk,	MD. 21222	
ē,	s 1 al f Hea item othe	1	20a. Method of Disposition		20b. Place of	Disposition (Name of	ice)	Date	20c. Location - City	
E S	Pages net of int: If it iry or o		1 X Burial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (S)		Gardens	of Faith Ceme	etery Ma	ay 23,2005	Rosedale, 1	MD.
Baltimore,	permit. Pages 1 and Department of Healt Importent: If item 2 any injury or other once.		21. Sunature of Funeral Service	Licensee		Connelly 7110 Sol	ess of Facility Funera Lers Po	l Home Of int Road,	Dundlak,P. Dundalk,Mo	A. l. 21222
	Trysician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Finaf	complications that conly one cause on e	aused the death. Do r	not enter the mode of dy		irdiac or respiratory a		Approximate Interval Between Onset and Death 9 Yeary
	/Medical		disease or condition resulting in death)	a Due to (	or as a consequence		<i>V</i> 1 -0	71-00-		0
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or njury	b. Due to (	or as a consequence	of):				
0	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (	or as a consequence	of):				
8760,	ate be ex hysician the buria	lical		d						
.O. Box 6	The law requires that the death certificate tie has been signed by the attending phys age 2 should be detached for use as the	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 ☐ Live b	come of pregnancy irth 2  Fetal death ant at time of death own	3 □Ectopic pregnants □ Other (specify)	су		23d. Date of d Month	delivery Day Year
ds, P.	uires that t i signed by id be detac		Part II. Other significant condition	ons contributing to de	eath but not resulting in	the underlying cause g	iven in Part I.			to the cause of death?  Probably 4 □Unknown
Vital Records,	hysician: The law require his certificate has been sig I director, page 2 should b	Completed						24a. Was auto perfe		autopsy findings available ocompletion of cause of ?
ta	ian: rtifica tor, p	0	25. Was case referred to medica				26. Place o	of Death (Check only		
t <	Physici this ce al direc	To B	examiner? 1 🗌 Yes - 🗱 No	Hospital: 1 🔲	Inpatient 2 ER/Ou	tpatient 3 DOA	ther: 4 🗆 Nurs	sing Home 542 Resi	idence 6 Other (S	pecify)
n of	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 □ Pendir	28a. Date (Mon		Time of 28c. Inj	ury at ork?		how injury occurred	
Sio		catle	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	gation			Yes 2 No		(Street and Number or	Gural Route Number
=	교등등	Certification;	4 Homicide determ	ined 289. Place	of Infury - At home, faing, etc. <i>(Specify)</i>	rm, street, factory, office	9	City or To	wn, State)	nulai noule Multiber,
	Hospite 24 hours Funeral	ledical Ce	29a. Certifier (Check only one)  Certifier  (Check only one)	Exeminer: On the b	best of my knowledge asis of examination an	e, death occurred at the d/or investigation, in my	time, date and opinion, death	place, and due to the occurred at the time.	cause(s) and manner date and place, and c	as stated. lue to the cause(s)
	To the within 2 To the comple	Med	29b. Signating and title opertifie		Λ.	29c. Lice	nse number		29d. Date signed (Mo	onth, Day, Year)
	- s - ŏ		by the	told 1	M News	ide D	19714	1	5/20/0	5
	1		30. Name and address of person	who completed cause	se of death (Itom 23a)	(Type, Print) [3	Alteri	- AVe 1	PALTIMORE	md21224
	St Regist	ate rar	31. Date filed (Month, Day, Year, MAY 2 0	2005	Registrar's Signature	Sporte	- W -		•	,

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Year **Physician** 15055 argarel 07:02 PM 2005 13 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Center 1505018a Saltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. Nov. 03, 1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 213-05-3117 Months 1 □ M 2 🛱 F 85 Maryland Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or flems 23s or 28a-f ahow other treumatic event. The Modical Exp. in or must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5500 Oakland Rd. 21227 U. S. A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. wnt: If item 27 Is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify: White Specify: by 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electronics Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Arthur Adams Reva Taylor ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Boss, son 5401 Fantail Dr. Eldersburg, MD. Health item 27 I 20a. Method of Disposition
1 △ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20b. Place of Disposition (Twing and Party MD - 17-05 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ite
any injury or ot Owings Mills, MD <sup>4</sup> □ Donation 5 □ Other (Specify) of Garrison Forest 21. Signature of Funeral Service Licensee Ambrose funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner chemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical attending IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy į in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown ģ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has 2 1 No 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ▼No 1 Inpatient 2 ER/Outpatient 3 DOA P 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: s after dec. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 24 hours a filled 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Tig Gertifying Priysician: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as states.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 To the 29b. Signature and title 29d. Date signed (Month, Day, Year) 13 2005 TCU Resident 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 S. Hanwer, ST S.M. Farasat, M.D 32. Registrar's Signature 31. Date filed (N State Registrar

DHMH 17 Rev 1/2001

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State of Man		rtment of Health a tificate of Death	nd Mental Hygiene Reg. No	2005 17011
	Physicia		1. Decedent's Name (First, Middle, Last)  CLARENCE C.	BEWIG		2. Date of Death Month Da MAY 16	ay 2005 3: Time of Death 7:00A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 8219 EDWILL AVENUE		4b. City, Town, or Location of ROSEDALE	Death 46	c. County of Death  BALTIMORE
	Funeral Director		216-24-8965 1™ 2□F	In yrs. last birthday) 75 Yrs.	If Under 1 Year If Under 2 Months Days Hours	84 Hrs. 8. Date of Birth (Month, Day, Year 8-8-1929	9. Birthplace (State or Foreign Country) MARYLAND
	Maryland a-f show		Usual Residence of Decedent  10a. State 10b. County 1  MD BALTIMORE	Oc. City, Town or Lo	cation		10d. inside City Limits 1 □ Yes 2 No
	with the 3a or 28	i Dire	10e. Street and Number 8219 EDWILL AVENUE		10f. Zip Code 21237	10g. C	U.S.A.
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural; or Items 23a or 28a-f show other traumatic event, the Medical Examination and illied at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Every Armed Forces?  1 ☒ Yes 2 □ No If Yes, Give Year or Dates:	l!	Nas Decedent of Hispanic Orig f Yes, specify Cuban, Mexican, i ☐ Yes 2 XNo Specify:	jin? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: WHTTE,
Maryland 21215-0036	within 72 hou ane. than "nature he Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  12	(Give	dent's Usual Occupation kind of work done during most DO NOT use retired)	of working	Kind of Business/Industry  DURKEE FOODS
land 2	uld be filed Aental Hygi rked other tic event.	To Be Co	17. Father's Name (First, Middle, Last)  CLARENCE C. BEWIG, SR.		A		ACHS)
Mary	nd 2 sho lith and N 27 is ma r trauma	1 2	19a. Informant's Name/Relationship (Type, Print) KATHERINE BEWIG/WIFE		ng Address (Street and Numbe EDWILL AVENUE		
nore,	Pages 1 ar	10.0	20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State		natory`or other place)		Location - City or Town, State
Baltimore,	permit. Pages Department of I Important: If Ite any injury or of		14 □Donation 5 □ Other (Specify)  21. Signature of Fun → Servi → Licensee	22		CVACH / ROSEDAI	LE FUNERAL HOME
	Pnysician /Medical		resulting in death)		eer the mode of dying, such as		Approximate Interval Between Onset and Death
8760,	cate be executed by yesician and the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	consequence of):			
.O. Box 687	The law requires that the death certificate be executed ite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	. □Fetal death 3 □	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Δ.	ires that signed b d be deta	þ	Part II. Other significant conditions contributing to death but				o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Records,	he law requ e has been age 2 shoul	Completed	DIVERTICULITY ( ORGANIZING ON	histor	y of)	24a. Was an autopsy performed?	
Vital	Physician: The this certificate har director, page	Be	25. Was case referred to medical examiner?		26. Place	of Death (Check only one)	
of	ng Ph fter th neral	on: To	27. Manner of Death  1 KNatural 5 Pending (Month, Day)	28b. Time o	nt 3 DOA 4 NE	rsing Home 5 Residence 28d. Describe how in	
Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injudent determined building, etc.	ry - At home, farm, st (Specify)			and Number or Rural Route Number, ate)
	e Hospital 24 hours 16 Funerel letely filled	Medical C	29a. Certifier (Chack only one)  12 Certifying Physician: To the best of and manner state and manner state.	examination and/or ir	in occurred at the time, date at nvestigation, in my opinion, dea	ith occurred at the time, date a	and place, and due to the cause(s)
	To the within To the comp	M	30. Name and address of person who completed cause of de	lio	License number	76 290. [	Date signed (Month, Day, Year)
	10		30. Name and address of person who completed cause of de	nath (Item 23a) (Type	POROB Patio	AJEWHA N	Ca, BAUO, Miles,
	St	ate	31. Date filed (Month, Day, Year) 32. Sigistra	r's Signature	P 10		

Registrar
DHMH 17 Rev 1/2001

			For	State of Mar	yland / Dep	artment of F	lealth and M	ental Hygie	ene	
			1 - For State Registrar			rtificate of		, ,	. No. 005	17012
	hysici	an	1. Decedent's Name (First, Middle,					2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	L112abett  4a. Facility Name (If not institution,		WHE	th City Taylor	at another of Dooth	05	18 200. 4c. County of Dea	
E	xamin	er	Levindale	give street and number)		1 1 1 1	r Location of Death  more: M	)	n/a	ui
Fu	ineral				In yrs. last birthday)			8. Date of Birth	9. Bir	thplace (State or Foreign
Dir	ector		220-09-3675	1□ M 2 7 F 8	8 Yrs.	World S Days		April 25	,1917 Mar	yľánd
land	A TI		Usual Residence of Decedent  10a. State 10b. County	1	IOc. City, Town or L	ocation				10d. Inside City Limits
Many	P-f sh	tor	Maryland Baltim	iore	Baltimo	re				1 ☐ Yes 2 ☐ No
ith the	or 28	Funeral Director	10e. Street and Number			10f. Zip Code		100	. Citizen of What C	ountry?
aath w	s 23a	erall	115 Dumbarton R	d. Apt. A	os in U.S. 12	21212	lianania Origin? (Sac	oit. Vac or No	U.S.A.	arican Indian
fter de	r item	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	Armed Forces? d 1 ☐ Yes 2 🗓 No	er in 0.5.	If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto F	Rican, etc.)	Black, Whi	
ours a	Era',	b	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 No	Specify:		Specify: W	nite
72 h	"natu	Completed	15. Decedent's (Specify only highest	grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of working	ng 16	6b. Kind of Business	/Industry
withii	r than	omp	Elementary/Secondary (0-12)	College (1-4or 5+) 1 Yr.	He	omemaker	-,		Own Home	
e filed	vent,	Be C	17. Father's Name (First, Middle, La				18. Mother's Name	(First, Middle, Ma	iden Sumame)	
lat yialitu KIKID-0000 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.	arked atic e	To	Morris		Levis		Elizabet		Willia	
0 0	7 is m traum		19a. Informant's Name/Relationshi Timothy L. Brown				and Number of Rural Apt . Rd. Balti			
te, IV	tem 2 other		20a. Method of Disposition		20b. Place of Dispo cemetery, cre		THE RESERVE AND ADDRESS OF THE PARTY.		c. Location - City or	
Pages nent of	nt: K		1 ØBurial 2 □ Cremation 3 14 □ Donation 5 □ Other (Spe			Cemetery		/05	Baltimore	,Maryland
Daltillore, IV permit. Pages 1 and Department of Health	Important: If them 27 is marked other then "natural, or flems 23s or 28s-f show any injury or other traumatic event, the Medical Exat. It withing the nutfilled at once.		21. Signature of Funeral Service Li	en See	2	2. N Mi Pchel	l¹ººWi defe ork Road			
ق ق	드루이		222 Part Enter the disease or o	omalication that arrived the	se death. Do not on					Approximate
			23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final	nly one cause in each line.				respiratory arres	ι,	Interval Between Onset and Death
	sician edical		disease or condition resulting in death)		consequence of):	- can	CCV			Wede
Exar	miner		Sequentially list conditions	b. ————————————————————————————————————						
pe	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
sxecut	al-trar	xan	that initiated events resulting in death) Last	c Due to (or as a	consequence of):					
The law requires that the death certificate be executed	physician and the burial-transit	cal	3	d						
artifica	ing ph e as th	ed	IF FEMALE:							
ath ce	the attending ploched for use as t	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir	☐Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	1		23d. Date of de Month	livery Day Year
j eg	y the ached	Physician/M	1 ☐ Yes 2 █ █ o 9 ☐ Unknown	9 Unknown	ne or death 5 (	_ Other (specify) _				
s that	signed by the atte d be detached for	by PI	Part II. Other significant condition	-1	// /	, ,	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
or d's,	been sig should b	eted	Cerebrova	SCU/ar	Jecia	eng		1 ☐ Yes	2 7No 3□P	robably 4 Unknown
i wa	2 2	Comple						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
<b>1</b>	certificate has rector, page 2	e Col	OF Was and referred to modical					1 Yes 2	Yes 1 ☐ Yes	2 □ No
vician:	s certi directo	o B	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatie	nt 3 DOA Oth	26. Place of Death er: 4 - ursing Hom		ce 6 □Other (Spe	cify)
5 fd :	After this certificate ha funeral director, page	T:uc	27. Manner of D th  1 Matural 5 □ Pending	28a. Date of Injury (Month, Day )			y at 2	8d. Describe how		,,
Attending death.	rector: A by the fu	icati	2 Accident investiga 3 Suicide 6 Could no	ation of he			Yes 2 □No	Of Location (Ctro	at and Number of O	ural Pauta Mumbas
i or Al	Direc I in by	ertification:	4 Homicide determin		y - At home, farm, st (Specify)	reet, factory, office	2	City or Town,	et and Number or R State)	urai Houte Number,
To the Hospital or Attending Physician: within 24 hours after death.	To the Funeral Dir completely filled in	calc	29a. Certifier 1 Certifying (Check only a Medical E	Physician: To the best of	my knowledge, deal	th occurred at the tir	ne, date and place, a	nd due to the cau	se(s) and manner a	s stated.
the H hin 24	the F	Medical	one)	xaminer: On the basis of e and manner state	id.					
T wit	2 0	-	29b. Signature and title of certifier	2 / m		29c. Licens	3943	290	Date signed (Mont	Jay, 1841)
	10		30. Name and address of person w	no completed cause of dea	ith (Item 23a) (Type.			0	11110)	, 1
10444	Y		Jusun M	1 Levy M	10	Levin	dale.	2434	W Beh	EderAve
F	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 0 26	05 Registrar	s Signature	de				

	For State Registrar		State of N	/laryland		artment rtificate			Mental H	ygien Reg. Ne	100		
Physician (Madica)	1. Decedent's Nam	e (First, Middle, Last) <b>T</b> • <b>B</b> U	TANI						2. Date of D Month MAY	Death Da	LUC	Year	3. Time of Death  2:30 P
/Medical Examiner	4a. Facility Name (i	f not institution, give s	treet and numbe	or)		4b. City, To		ocation of Dea	ath	40	ONTG		
Funeral Director	5. Social Security N 226-69-6	100	M 2□F	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hr Hours Mir		irth Day, Year <b>9,</b> 1	913	9. Birthp Coun INDI	
faryland show	Usual Residence of 10a. State	10b. County	DV		, Town or Lo	ocation	,					11	Od. Inside City Limits 1 ☐ Yes 2 ▼No
with the Ma e or 28e-f	MD 10e. Street and Nu			ВЕТН	ESDA	10f. Zip C					itizen of W	/hat Coun	try?
be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "netural", or items 23e or 28e-f show event, its Madrel Examiner must be notified at Re-Commissed by Funeral Director	3 ₩ Widowed	ied 2 Married 4 Divorced  15. Decedent's Educ	12. Was Deceder Armed Forces 1  Yes 2 5 If Yes, Give Year or Dates	s? ₹No	16a, Dece	1 ☐ Yes 21	nt of His y Cuban No	Specify:	Specify Yes or Norto Rican, etc.)		14. Race	AJI	AN
ind 21215-00 be filed within 72 hou tal Hygiene d other than "neture event, the Michael	Elementary/Second 12		College (1-4o	r 5+)	life.	L SERV	VANT			OF	DEFE	ENSE	TMENT
Maryland 212 d 2 should be filed within the and Mental Hygiene. 77 is marked other than traumatic event, the Maryland To Be Common	TOLARAM							LALI JI	ANDANI				
Main on d 2 sk and the and 2 sk and the and 27 is and it is an and it is an analysis of a shape of the interest of a shape of	DEEPAK B	ame/Relationship (Ty) UTANI - SO	, ,	1	9718	BRIAR	CLIF		Rural Route Num	TT,	MD 21	042	
imo Pages nent of ant: If i		position  Cremation 3 □R 5 □ Other (Specify)	emoval from Stat	te ce	emetery, crei	osition (Name matory or oth VA. CRI	er place,	1	Date 718/05		ocation -	•	
Balt Depart Import any injuries	21. Signature of F	peral Service License	ables	~	100				ARLINGTO			0.00000	E 203
Physician /Medical Examiner	shock, or hea Immediate Cause disease or condition resulting in death)	on f	ASPIF	RATION	PNEUM			such as cardi	ac or respiratory	arrest,			Approximate Interval Between Onset and Death HOUR
58760, circle be executed physician and site burial-transit	Sequentially list oc If any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death)	erlying injury	s	as a consequ									
Records, P.O. Box 6 The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	IF FEMALE: 23b. Was deceder in the past 12 1  Yes 2 9  Unknown	months?	3c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal at time of de	death 3	⊒Ectopic pred ☐ Other (spec					23d. Date Mor	e of delive	ry Day Year
rds, P tuires that n signed b	Part II. Other signi	ficant conditions cor	ntributing to death	but not resu	ılting in the u	indertying cai	use giver	n in Part I.					e cause of death? ably 4  Unknown
									per	as an topsy formed? 2X N	p d	Vere autor rior to cor eath?	osy findings available inpletion of cause of
TCON, TNC Division of Vital I tal or Attending Physician: Th is after death. at Director: After this certificate ed in by the funeral director, page	1 Yes 2	No H  S Pending investigation 6 Could not be	dospital: 1 Inpa 28a. Date of Ir (Month, L	njury Day Year)	ER/Outpatier 28b. Time o Injury	f 28	c. Injury : Work?	4 Nursing	Home 5 Re 28d. Describ	sidence e how inju	ury occurr	bed	r) I Route Number,
Division Part of All Hospital or All Hours after de Funeral Direct leif filled in by		determined	building,	etc. (Specify	")			date and nic	City or T	own, Sta	te)		
the order	(Check only one)  29b. Signature and	2 Medicel Examin		of examinat		vestigation, i		nion, death oc		e, date ar	nd place, a	ind due to	
	> Ar	athan		& days to	020) 7	DO	0053				17,		
3	ARUNA		1125 ROC	CKVILL	E PIKE		re 20	08, ROC	KVILLE,	MD	2085	2	
State Registra		ntn, Day, Year)		strar's Signa	ui e								

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State	of Mai	ryland / De <i>C</i>	oartmer e <i>rtificat</i>				lental Hy	gien Reg. N	200	7 600	170	1 1
			Decedent's Name (First, Middle	e, Last)							2. Date of De		o. () !	11	3. Time of	Death
	Physici		Cheryl Theresa	D1 also							Month		ay	Year	7:40	$P^{M}$
	/Medic Examin		4a. Facility Name (If not institution		umber)		4b. City.	Town, or	r Location of	of Death	May 15		005 c. County	of Death	7:40	P
	Lamin	ICI	4850 Ruggles Ro				_	eytor					Carro			
	Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. last birthda	y) If Unde	r 1 Year	If Under		8. Date of Bi	rth		9. Birthp	lace (State of	r Foreign
	Director		219-66-2573	1 ☐ M 2 🙀 F		48 Yrs.	Months	Days	Hours	Min.	(Month, Da April	ay, Year 26 -	1957	Coun	try)	
	g		Usual Residence of Decedent											1141		
	rylan	_	10a. State 10b. County			10c. City, Town or	Location							1	0d. Inside Cit	
	e Ma	cto	Maryland Carr	·o11		Tane	ytown								1 🗆 Yes	2 🔀 No
	or 28	Jire	10e. Street and Number				10f. Zip	Code				10g. C	itizen of V	What Coun	try?	
	23a	la l	4850 Ruggles Ro	ad				217	787				Unit	ed S	tates	
	be filed within 72 hours after death with the Maryland tal Hyglene. d other then "natural", or items 23a or 28e-f show event, tre M. Alcel Exchibit matter matter milital at	<b>Funeral Director</b>	11. Marital Status	12. Was Dec Armed F	cedent Ev	ver in U.S. 1	l Was Dece	dent of H	ispanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	)-		e - Americ		
õ	or it	Y.F.	1 Never Married 2 Marr	If Yes, G	2KNo ive		1 ☐ Yes		Specify:					. Whi		
9500-61212	ural',	d by	3 Widowed 4 Divorced	Year or I	Dates:											
ភ្ន	"nat	Completed	15. Deceden (Specify only higher	t's Education st grade completed	)	(G	edent's Usu ve kind of wo	rk done o	during mos	t of worki	ing	16b.	Kind of Bu	usiness/Inc	lustry	
7	within 72 ene. then "nat	ш	Elementary/Secondary (0-12)	College	(1-4or 5+)	)	. DO NOT u		,							
	filed v Hygie other t		12 17. Father's Name (First, Middle,	( act)		Ent	repre	neuse		or'n Alama	First, Middle				usines	S
/land		Be	John P. Dull	CB3i)										,		
	2 should be and Menta Is marked sumetic evan	2		his Circa Crist				(0)		1000	t L. Ov					
Mar	12 sho h and 7 Is mu traum		19a. Informant's Name/Relations Robert Blake /								al Route Numb neytown				Code)	
	s 1 and 2 should f Health and Mer item 27 Is marke other traumetic		20a. Method of Disposition			Andrew Control				the second	Date			City or To	um State	
<u></u>	Pages nent of H int: If ite		1 ☑ Burial 2 ☐ Cremation		State	20b. Place of Dis				May 1	19,	200. 1	_ocation =	City or 10	WII, SIAIO	
	t. Partmer rtmer rtant njury		`4 □Donation 5 □ Other (S			Resthave									arylan	.d
Baltimore,	permit. Pages 1 Department of He Important: If iter any injury or oth		21. Signature of Furieral Service	2007588							ervices					
		4	One Oracle Should discount of	Saliantiana that	anusad th						lwy. Fr		rick,	MD .		
			23a. P. 1. Enter the disease, or shock or heart failure. List	one cause on	each line		mer me mod	le or dyin	. C	cardiac	or respiratory a	rrest,			Approximate Interval Betw Onset and D	veen
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	511	oblaston	a W	with	itorn	2					13 mos	nthi
	/Medical Examiner		resulting in death)	Due to	(or as a	consequence of):										
		L	Sequentially list conditions,	b. Due to	/== == =									_		
7	pe ji	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a	consequence of):										
	and tran	Examiner	that initiated events resulting in death) Last	c.	lor as a	consequence of):								_		
Ď,	cate be executed ohysician and the burial-transit				(01 43 4	sonsequence on).										
9/8	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical		d						_						
و ×	leath certific attending p I for use as	Physiclan/Me	IF FEMALE:	23c. If yes, or	rtcome of	nreanana.										
X Q R	atten atten for us	an	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2	☐ Fetal death	Ectopic p						23d. Date Mor	e of delive nth		ear
o.	the de	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9□ Unki		me of death	Other (sp	pecity)								
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က်	signe signed bed	l by					and only in ig	auto g. r.				Yes 2			abiy 4 <b>⊠</b> ∜	
Kecords	w require been sis	Completed									-	<del>.</del>				
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	sician: The law certificate has l irector, page 2 s	Co									1 ☐ Yes	rmed? 2 N		leath?	2□ No	
VITal	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?					0.1		of Death	(Check only	one)				
0	Physi this c	2	1 ☐ Yes 2 No		Inpatient	The state of the s			4 🗆 140		me 5XResi				)	
	Wite	on:	27. Manner of Death 1 X Natural 5 ☐ Pendin	g 28a. Date	of Injury oth, Day 1	Year) 28b. Time Injur		28c. Injury Work	k?		28d. Describe	how inje	ary occurre	ed		
<u> </u>	Attending or death. ector: After by the fune	catl	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	not be			М		Yes 2□!	-						
UIVISION	or At Iter d irect n by	Certification:	4 Homicide determ	ined 200. Plac		y - At home, farm, (Specify)	street, factor	y, office		1	28f. Location ( City or To			er or Rurai	Route Numb	00 <i>r</i> .
	ital c															
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	edical	(Check only 2 Medicel	g Physicien: To the Exeminer: On the I	e best of basis of e	my knowledge, de examination and/or	ath occurred investigation	at the tim	ne, date an	d place, a	and due to the ed at the time,	cause(s	s) and mai	nner as sta	ated. the cause(s)	
	the I hin 2 the I mplet	Med	One)	and mai	nner state	ed.										
	Will Cor	-	29b. Signature and title of certifie				290		number			290. Da	ate signed	(Month, L		
			Ch	- 14	<u></u>			200	06101	40			17/1	0/2	005	
	3		30. Name and address of person	who completed cau	se of dea	ith (Item 23a) (Typ	e, Print)		71 1		11 - 1	1				
			Char	les IZU	din	MD	Jol	24	Hopk	(In)	Hospita	J				
	Sta Registr		31. Date filed (Month, Day, Year)	103	Hegistrar'	's Signature	we		V							
Di.		-81	MAY 2 0	ZUUD JOB	S. M. J.	IN MA	1									
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DHMH 17 Rev 1/2001

		•	State of N	laryland / Department of Health and M Certificate of Death	Reg. No. 2000 1/015
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last)  MILDRED M.  4a. Facility Name (If not institution, give street and number ROCK SPRING VI	BOKEL  4b. City, Town, or Location of Death  LLAGE FOREST HIL	2. Date of Death Month O5 17 2005 10:00AM  4c. County of Death HARFORD
IF .	Funeral Director			ge (In yrs. last birthday)    If Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)  12-22-20  9. Birthplace (State or Foreign Country)  MARYLAND
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "naturel", or items 23e or 28e-f show injury or other treumatic event, "ite Medical Exatr har must be maillised at injury or other treumatic event, "ite Medical Exatr har must be maillised at 8.	Director	10a. State 10b. County  Harford  10e. Street and Number	10c. City, Town or Location  FOREST HILL  10f. Zip Code	10d. Inside City Limits  1  Yes 2 No  10g. Citizen of What Country?
036	urs after death v el', or Items 23a	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  1 Yes, Give Year or Dates	17 If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ANO Specify:	Pocify Yes or No-Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White.
21215-0036	filed within 72 ho Hygiene. other than "natur ant, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4o	Nomeniaker	at home.
Maryland	2 should be fit and Mental H is marked out reumatic even	To Be	17. Father's Name (First, Middle, Last)  19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rura	a (First, Middle, Maiden Sumame)  Al Route Number, City or Town, State, Zip Code)
Baltimore, 1	permit. Pages 1 and Department of Health Important: If item 27 any injury or other t once.		20a. Method of Disposition  1 Durial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)	e More land Man Park 5-2	20c. Location - City or Town, State
Bal	permit Depar Impor any in		23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on act		FL-BELAIR 3 NEW PORTUR.  or respiratory arrest,  Onega and Death
Name of Street	Physician /Medical Examiner		Sequentially list conditions b.	consequence of):	Byzars
760,	icate be executed physician and s the buriat-transit	cal Examine	cause. Enter Underlying Cause (Clesace or Injury) that initiated events c.	as a consequence of):	
.O. Box 68	The law requires that the death certificats the has been signed by the attending phy bage 2 should be detached for use as the	Physician/Medi		2 Fetal death 3 Ectopic pregnancy at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
Ω.	w requires that been signed by should be deta	b	Part II. Other significant conditions contributing to death	but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown
Vital Records,		Be Completed	25. Was case referred to medical examiner?		24a. Was an autopsy performed?   24b. Were autopsy findings available prior to completion of cause of death?   1   Yes 2   No   (Check only one)
Division of \	ending Physiath. or: After this he funeral di	Certification: To	2 Accident investigation	njury 28b. Time of 28c. Injury at Work?  Injury M 1 □ Yes 2 □ No	me 5 Residence 6 Other (Specify)  28d. Describe how injury occurred
Divi	To the Hospitel or Atti within 24 hours after de To the Funeral Directo completely filled in by t		4 Homicide determined 200 Place of building.  29a. Certifier 1 Certifying Physician: To the be	Injury - At home, farm, street, factory, office etc. (Specify)  st of my knowledge, death occurred at the time, date and place,	
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Examiner: On the basis and manner 29b. Signature and title of certifier	of examination and/or investigation, in my opinion, death occur stated.  29c. License number	29d. Date signed (Month, Day, Year)
	10		30. Name and address of person who completed cause of the control	of death (Item 23a) (Type, Print)  M.D. /205 York Rd.	Luthenille Md. 21093
DI	Regist		2005	and A Asile	

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** May 4, 2005 11:24 AM Bernard Baskerville /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 2030 Christian Street | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 5, 1940 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number **Funeral** Mary land Months 1**X**) M 2□ F 213-36-4155 Yrs. 64 Director Usuel Residence of Decedent 10d. Inside City Limits 10a, State 10b. Count 10c. City, Town or Location 28a-f ehow the Medical Examiner must be notified at 1X Yes 2 No Baltimore MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21223 USA or items 23a or 2030 Christian Street permit. Pages 1 and 2 should be flied within 72 hours after death a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel", or items 23a eny Injury or other traumatic event. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 black. 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) unk 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry Elementary/Secondary (0-12) unk College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk Baltimore City Police Dept 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 □ Donation \_ 5 X Other (Specify) in state 21. Signature of Euneral Ron 1 d State Anatomy Board 655 W. Baltimore Street S. Wade? cost 21201 Baltimore, MD Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ease years Pnysician Lidney disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner 3 4000 ev NS 01 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a ednsequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit nem and Due to (or as a consequence of): P.O. Box 68760. led by the attending physician detached for use as the buria hronic Q 111 carl Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 🔯 Unknown After this certificate has been si funeral director, page 2 should it Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 🗵 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the within 24 hours after death To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2005 RADCLI Hom 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SPB NORTHERN a 31. Date filed (Month, Day, Year) Registrar's Signature State MAY 2 0 2005 Registrar

			1 - For State Registrar	e of Marylar		artment of H <i>rtificate of L</i>	ealth and Me Death	ental Hygier Reg. i		17017
			1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
Н	Physici /Medic		Joffre	C	hess,	II	į.		Day Year えでの	11:35 M
	Examir		4a. Facility Name (If not institution, give street and				Location of Death	1	c. County of Death	
٠	_xaiiii		Prince George's K	tos sital		che	verla	1	Prince Go	eore Ir
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	9 Date of Birth	O Diethe	alaga (State or Familia
	Director		428-57-3681 X M 2 D	F 19	Yrs.	Months Days	Hours Min.	June II,	1985 Hamm	ond, IN
	р.		Usual Residence of Decedent							
	how	_	10a. State 10b. County	10c. Ci	ity, Town or Lo	ocation			1	IOd. Inside City Limits
	a Ma	당	IN Lake	·	Gary					1 ☐ Yes 2 ☐ No
	th th	Director	10e. Street and Number			10f. Zip Code		10g. (	Citizen of What Cour	ntry?
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ont, the Medical Examiner must be notified at		2000 West 5th Ave #10	1		46404			USA	
	dea	Funerai	Arme	Decedent Ever in U d Forces?		Was Decedent of Hi	spanic Origin? (Spec n, Mexican, Puerto R	cify Yes or No-	14. Race - Amend	
9	or it	F	1 Never Married 2 Married 1 1	es 2 ANo Give	i		Specify:	noan, etc.)	Black, White,	etc.
2-0036	ours	d by	3 ☐ Widowed 4 ☐ Divorced Year	or Dates:		1 ☐ Yes 2 ☐ No	эреспу.		Specify: B	lack
'n	72 h 'natu	Completed	15. Decedent's Education (Specify only highest grade comple	ted)	(Give	dent's Usual Occupa	luring most of working	16b.	Kind of Business/In	dustry
2	ithin nan '	npi	Elementary/Secondary (0-12) Colle	ge (1-4or 5+)	life.	DO NOT use retired,	)		_	
2	filed w Hygier other tl	S		1	Se	rver	<del></del>		Restaura	nt
Maryland 2121	m - 0 2	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		en Sumame)	
<u>   </u>	should be ind Mental I	은	Joffre D. Chess, I				Alice N			
<u>a</u>	2 sh and is m		19a. Informant's Name/Relationship (Type, Print)	1			ind Number or Rural			Code)
	and ealth n 27		Alice Chess - Mother		_	ALL STATE OF THE S	th Ave #10	01 Gary,	IN 46404	
ore	of H		20a. Method of Disposition 1		Place of Dispo cemetery, crea	osition (Name of matory or other place	p) Da	te 20c.	Location - City or To	own, State
Ĕ	Pages nent of I		'4 □Donation 5 □ Other (Specify)	Ev	ergree	n Cemeter	y 5-14-	-05 Но	bart, IN	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny Injury or other traumatic ex once.		21. Signature of Funeral Service Licensee	0066		Name and Address AII	s of Facility en Funeral	Director	s S	
			23a Part1. Enter the disease, or complications the	nat caused the deal			11th Aver		IN 46404	Approximate
lo.	2 ×	4	shock, or heart failure. List only one cause	on each line.						Interval Between Onset and Death
	Pnysician / /Medical		resulting in death)			cident w	ith multi	ple Inje	wies	
	Examiner		Due	e to (or as a conseq	quence of):					
		er	Sacuentially list conditions b.	e to (or as a conseq	ulence of):					
1	ed Isit		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	3 10 (c) us u conseq	(Berice Oi).					
1	cate be executed physician and the burial-transit	Examin	that initiated events c.	to (or as a conseq	uence of):					4-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0
8760,	be e ician buria			(-1 40 4 00 100 100 1	, 20,700 0.7,					
8	cate phys	dicai	d							
×	death certifi e attending id for use as	/Me	IF FEMALE: 23c If yes	, outcome of pregna	2004					
X P P	atten for us	Physician/M	in the past 12 months?	ve birth 2 Feta	aldeath 3□	Ectopic pregnancy			23d. Date of delive Month	Day Year
o.	at the de by the a tached	ysic		regnant at time of d inknown	eath 5L	Other (specify)				,
ı.	that the	P	Part II. Other significant conditions contributing	to death but not res	sulting in the u	ndertving cause give	n in Part I	23e Did tobacco	use contribute to th	A cause of death?
Š	signe bed I	by	Takin ener eigimean eenan een een een een een een een ee	io dodin bat not res	ouning in the u	moenlying cause give	ii iii Fait i.			
5	w require been si should?	stec						1 🗆 Yes	24 110 3 F100	ably 4 Unknown
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I		DO.						performed?	death?	
<u>=</u>	sician: The law certificate has b irector, page 2 s	Be (	25. Was case referred to medical examiner?				26. Place of Death			
010	hysic nis ce I dire	2		☐ Inpatient 2 ☐	ER/Outpatien	nt 3□ DOA Othe	F: 4 Nursing Home	e 5 Residence	6 ☐Other (Specify	')
0	ding Ph h. After th funeral	Ë	1 Natural 5 Pending	ate of Injury Month, Day Year	28b. Time of Injury	f 28c. Injury Work		d. Describe how inj	ury occurred	over it
<u>0</u>	andia path. or: A	cation;	2 Accident investigation APV	127,2005	0455		es 2 ₽No	ichode	struck an	sines
UIVISION	er der recte	ţį	3 ☐ Suicide 6 ☐ Could not be determined 28e. P	lace of Injury - At he uilding, etc. (Specif	ome, farm, str	eet, factory, office	28	If. Location (Street a	and Number or Rura	Route Number,
5	tal o	Certifi				Treet		MAGIANO	near 5	e-brock
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funerel Director: After this certifica completely filled in by the funeral director.	edical	29a. Certifier (Check only one)  1 ☐ Certifying Physician: To 2 ☑ Medical Examiner: On the and of an of the control of the co	the best of my kno ne basis of examina nanner stated.	owledge, death	n occurred at the time vestigation, in my op	e, date and place, an inion, death occurred	d due to the cause/	s) and manner as st	ated
	To the within To the comple	-	OOL Circum and title of andifica			29c. License	number	29d. D	ate signed (Month, I	Day, Year)
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	2		The reach 12	, , ,	- 00-1-7	2003	2141	10/10	7 1	
	2		30. Name and address of person who completed SALVA LON SINGLE (Month, Day, Year) MAY 2 0 2005	3001 He	n 23a) (Type,	L Druve	chever	ly Mar	, land	
	Sta	te	31. Date filed (Month, Day, Year)	. Registrar's Signa	ature	w :		11	/	
	Registr	ar	MAY 2 0 2005	Maries B	A					

			1 = For State	State of Maryland	/ Department of Health  Certificate of Death		ZUII:5 17018
	Physici /Medic		1. Decedent's Name (First, Middle, Last,	Carbin	Commodic of Dodg	2. Date of Death	Day Year 3. Time of Death 12/5/AM
	Examin		4a. Facility Name (If not institution, give on AR NCL HEALT	street and number)  14 OF BCL-ACK	4b. City, Town, or Location Bel-A:R		4c. County of Death HARFORD
	Funeral Director		5. Social Security Number 6. Sec 315-01-8840	7. Age (In yrs. last	Yrs. If Under 1 Year If Under 1 Year Hours	m 24 Hrs. 8. Date of Birth Min. Min. Feb. 3, 19	9. Birthplace (State or Foreign Couptry) North Carolina
	Maryland -f show lied at	tor	10a. State 10b. County	10c. City, T	own or Location altimore	· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits 1 ▼Yes 2 □ No
	h with the	Funeral Directo	10e. Street and Number	aton Ave F	pt. 10f. Zip Code	10g.	Citizen of What Country?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene, item 27 is marked other than "natural; or items 23e or 28e-f show other traumatic event, the Medical Evarine finals Le rollified at	by Funer	1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic O If Yes, specify Cuban, Mexica  1 ☐ Yes 2 No Specify		14. Race - American Indian, Black, White, etc.  Specify:
215-0036	iin 72 houn n "natural" Aedical Ex	Completed b	3 Widowed 4 □ Divorced  15. Decedent's Edu (Specify only highest grad	cation 1 completed)	6a. Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired)	st of working	Kind of Business/Industry
2	be filed within tal Hygiene. d other than "avent, the Me	Be Com	Elementacy/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Domestic 18. Moth	ner's Name (First, Middle, Maid	House Keeper
Maryland	2 should be and Mental is marked o	To	Wonda  19a. Informant's Name/Relationship (Ty	po, Print) nephew)	19b. Mailing Address (Street and Numb	argaret Der or Bural Roule Number, Cit	Haliday y or Town, State, Zip Cobe)
	Pages 1 and 2 nent of Health out: If item 27 iry or other tra		20a. Method of Disposition  1 Burial 2 Cremation 3	com	e of Disposition (Name of etery, crematory or other place)	er   rail = 200. 5/27/2005 = T	Lunction - City or Town, State
Baltimore	permit. Pages Department of Importent: If ii any injury or conce.		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens		timore National 2 2 Name and Address of Facil Joseph L. Rus	lity Funeral	Home, P.A.
			23a. Part / Enter the disease, or compl shock or heart failure. List only or Immediate Cause (Final	cations that caused the death. I	Do not enter the mode of dying, such as	s cardiac or respiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consequen	ge Venen	hа	years
	cuted nd ransit	Examiner	if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequen	ice of):		
8760,	ate be executed thysician and the burial-transit	ical	resulting in death) Last	Due to (or as a consequent.	ice of):		
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
rds, P.	quires that in signed by uld be deta	b	Part II. Other significant conditions cor	ntributing to death but not resultin	ng in the underlying cause given in Part	1. 23e. Did tobacc	o use contribute to the cause of death?  2 FNO 3 Probably 4 Unknown
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of	ling After une	<b>-</b>	27. Mann i Death  1 Natural 5 Pending 2 Accident investigation		/Outpatient 3 □ DOA	rsing Home 5 ☐ Residence 28d. Describe how in No	
Division	tal or Attandi s after death. al Director: A ad in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	edical	(Check only 2 Medical Exami	sician: To the best of my knowle ner: On the basis of examination and manner stated.	dge, death occurred at the time, date a and/or investigation, in my opinion, de	ath occurred at the time, date a	and place, and due to the cause(s)
	To To	Σ	29b. Signature and title of certifier	106) -	29c. License number	29d. I	Date signed (Month, Day, Year)
	X		30. Name and address of person who co	mpl- d calso f death (Item 23	Ba) (Type, Print)	Law Street	21001
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Anaelle )	(berdeen)	Maryland
	Registr	ar	MAY 2 0 2005	BROWN ST P	Coole		/

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Town Social Security Number If Under 1 Year Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, **Funeral** 212-42-6750 Usual Residence of Decedent 1□M 2 F Director filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hygiene. other than "natural", or Items 23a or 28a-f ehow ent, the Medical Examinar must be notified al Marylana 1 XYes 2 ☐ No **Funeral Director** more 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Was Decedent Ever in U.S Armed Forces? 12. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementacy/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fil and Mental H is markad ott Be Pages 1 and 2 should Dak wmar 19a. Informant's N me/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 is en 20b. Place of Disposition (Name of or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. ö \* 4 ☐ Donation 5 ☐ Other (Specify) raine 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
JOSEPH L. RYS h L. Ryss Funeral Home, P. A. W. North Ave. Balto. Md. 21216 23a. Port1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscleration Pnysician /Medical Due to (or as a consequence of) **Examiner** Deitensich Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed men (or as a consequence of) Records, P.O. Box 68760 Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 A No Division of Vital Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: P 1 ☐ Yes \_ 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After t Certification: Injury 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes investigation Diractor: 3 ☐ Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) after 4 - Homicide 24 hours a 29a. Certifier 1🕱 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Macero MD 15503 molan M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMATUM N HAEEM 501 DOLPHIN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAY 2 0 2005

DHMH 17 Rev 1/2001

			State of Maryland / Department of State of Stat	of Death	Reg. No.	17020
- 1	Physici /Medic		1. Decedent's Name (First, Middle, Last)	2. Date of Month	/ Pay Year	3. Time of Death
	Examir	700	FUTURECARE HOMEWOOD BAI	m, or Location of Death TIMORE  ear   If Under 24 Hrs.   8, Date of	4c. County of Dea	
	Funeral Director			ays Hours Min. (Month	n, Day, Year)	rthplace (State or Foreign Country) ryland
	//aryland f show	or	10a. State	37		10d. Inside City Limits  ty□ Yes 2 □ No
	or 28e-	Funeral Director	10e. Street and Number 10f. Zip Co		10g. Citizen of What C	Country?
	ath wi	ral	000 218110 201 11901	1230	U.S.A.	de la disc
036	72 hours after death with the Maryland natural', or Itams 23e or 28e-f show Jical Erat. is at must be Lottified at	b	11. Marital Status  1  Never Married 2 Married  3  Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1  Yes, 3 Poolegen If Yes, specify of Yes, Give Year or Dates:	of Hispanic Origin? (Specify Yes of Cuban, Mexican, Puerto Rican, etc. No. Specify:	Specific	
21215-0036	C *_ D	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  O  College (1-4or 5+)  Homemaker	one durina most of workina	16b. Kind of Busines:	
	77 (7)	e Co	9 NOMEMAKET  17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mi		
Maryland	Mental Mental arkad aric av	To B	Bernard Roepke	Ethel Rein		7: 0: 41
<u>8</u>	nd 2 sho Ith and 27 is mu			reet and Number or Rural Route N t. Apt. 303 Balt		
Je,	of Health of Health fitem 27		20a. Method of Disposition 20b. Place of Disposition (Name	of Date	20c. Location · City o	
altimore,	Pages ment of I ant: If it		'4 Donation 5 Other (Specify)  Bayview Cremato	ry,Inc 5-19-05	Baltimore,	-
Balt	permit. Pag Department Important: I any injury o		Veorge M. Hamplow M. 130 E. F	<sup>ddress of Facility</sup> McCully- ort Ave. Baltimo	re, Maryland	. Home P.A. 21230
Ď.			23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.	dying, such as cardiac or respirate	ory arrest,	Approximate Interval Between Onset and Death
f	Physician /Medical		disease or condition resulting in death)  Due to (on as a consequence of):			
. 1	Examiner		Sequentially list conditions, b. Progressive .	De chue		
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury			
o,	be executed sician and burial-transit	Exar	that initiated events resulting in death) Last Due to (or as a consequence of):			
68760,	ficate be physicial sthe bu	edical	d. Hypertensus			
.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnant at time of death 9 □ Unknown  3 □ Ectopic pregnant at time of death 5 □ Other (specific pregnant at time of death 9 □ Unknown		23d. Date of de Month	elivery Day Year
ds, P.	uires that signed by Id be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause		Did tobacco use contribute t	to the cause of death?
Vital Records,	The law requir ate has been si page 2 should I	Completed	Amnie Lee Odeng		Was an 24b. Were a autopsy prior to death? es 2 2 No 1 □ Ye	
		Be C	25. Was case referred to medical examiner?	26. Place of Death (Check of		
ō	Phys this ral dir	၉	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA		Residence 6 Other (Sparite how injury occurred	ecify)
ē	tth :: After s funer	ation	1 ⊟Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation M	Injury at Work? 1 ☐ Yes 2 ☐ No	noo now injury occurred	
DIVISION	Hospitel or Attending 14 hours after death Funaral Director: After tely filled in by the tune	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, or building, etc. (Specify)	fice 28f. Locati City o	on (Street and Number or F r Town, State)	Rural Route Number,
	To the Hospitel or within 24 hours afte To the Funaral Director Completely filled in I	edical 0	29a. Certifier (Check only one)  1 Gertifying Physician: To the best of my knowledge, death occurred at to the death occurred at the control of the death occurred at the deat	ne time, date and place, and due to my opinion, death occurred at the t	the cause(s) and manner a	s stated. e to the cause(s)
	To the within 2 To the complet	M	Deuta mo	SIV64	29d. Date signed (Mon	05
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHOAIS A. HASHMI, &ZIN, &	taw St Sm	E 308 13.	all moziz
	Sta Regist		31. Date file or (Mary Year) 32. Registrar's Signature			

State of Maryland / Department of Health and Mental Hygiene T = For State Registral Certificate of Death 2. Date of Death 3. Fime of Death 1. Decedent's Name (First, Middle, Last) Month <sup>Day</sup> 2005 **Physician** 9:30 AM 17 REBA WINTERS CULP May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14 Holly Branch Court Glen
If Under 1 Year
Months Days Baltimore County Arm If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Hours 1□M 210 F 96 Director Apr 10, 1908 218-34-1226 Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28e-f show 77 Is marked other then "naturel", or Items 23a or 28e-f shor treumatic svent, Ire M. cital Examiner must be notified at 1 ☐ Yes 2 📉 No Stoneleigh Completed by Funeral Director Maryland Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 USA 903 Greenleigh Road filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Residence 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be in nent of Health and Menfal I ent: If item 27 is marked o Winters Hannah Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dr. Clifford L. Culp, Jr. (Son) 1306 St. Paul's Way, Crownsville, Maryland 21032 other Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) 5 permit. Page Department of Importent: if eny injury or once. Govans Presbyt.Cem. 5/20/2005 Baltimore, Maryland 21. Signature of Fungal San Defraction D. Lawson 22. Name and Address of Facility Lawson Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 100 to Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ban che y 2 2 wouths Priysician ناع MERY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter this right Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and burial-transit Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical the ding pl 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown jo Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a o 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. sign I be 1 Yes 22 No 3 Probably 4 Unknown been signal 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes Division of Vital Affer this certification funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) daughters Aser Other: 4 Nursing Home 5 Residence 6 ther (Specify, Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М Accident the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 5-17-05 D13272 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7505 Osler Drive, # 403, Towson, Maryland 21204 Robert Stoner, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State MAY 2 0 2005 Registrar

		1	For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of He tificate of D		ental Hygier Reg.	en en	17000
	Physicia		1. Decedent's Name (First, Middle, Last,	-	6.1			2. Date of Death Month 5	Pay Year 2005	3. Time of Death
	/Medic	al -	James Milto  Ha. Facility Name (If not institution, give		LY	4b. City, Town, or L	ocation of Death		4c. County of Deat	
	LXammi	ÇI.	607 Pennsylvania	Avenue		Balto			N/A	
	Funeral		5. Social Security Number 6. Se	x 7. Ag ] M 2 ☐ F	e (In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birt	hplace (State or Foreign untry)
	Director	-	239-20-1145 Usual Residence of Decedent	3.11.	82 Yrs.			4-19-19	923	N.C.
	yland 10w		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	e Mar	ctor	Md	N/A	Balto					1 X Yes 2 □ No
	vith th	Dire	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?
	eath v	Funeral Director	607 Pennsylvania	12. Was Decedent	Ever in U.S. 13. \	21202 Was Decedent of Hisp	panic Origin? (Spe	cify Yes or No-	14. Race - Ame	nican Indian,
36	72 hours after death with the Maryland natural; or items 23a or 28a-f show deat Examinational bearafilled at	þ	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces?  1 XYes 2 1  If Yes, Give Year or Dates:	No	f Yes, specify Cuban,	Mexican, Puerto F Specify:	Rican, etc.)	Specify: B1	e, etc. ack
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Madical Examination and the mailtied at 200ce.	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occupati kind of work done du DO NOT use retired)	on ring most of workin	16b	. Kind of Business	Industry Unk
21	ygien ygien her th		8th grade	N,	/A	Welder	O Markharda Marsa	(First, Middle, Maid	for Current	
Maryland	d be fill and officed office	Be	17. Father's Name (First, Middle, Last)  Charles James I	lancv		['		re McLaug		
aryl	should nd Me mark umati	2	19a. Informant's Name/Relationship (T)		19b. Mailir	ng Address (Street an				Zip Code)
M.	and 2 alth a 127 is er trau		Arlette Dancy - Da	ughter		trawhat Ro		ngs Mills	, Md 2111	.7
altimore,	ges 1 of He If itam or oth		20a. Method of Disposition  1X  Burial 2 □ Cremation 3 □ I	Removal from State	20b. Place of Dispo cemetery, crer	sition (Name of natory or other place)	l I		. Location - City or	
ij	it. Partmen rtant: njury	4	<ul> <li>4 ☐ Donation 5 ☐ Other (Specify,</li> <li>21. Signature of Funeral Service License</li> </ul>			Cemetery  Name and Address	4.00		wings Mil	ls, Md
Ba	perm Depa Impo any ii		1 ximala	Jun	nu.	4300	Wabash	ch F/H <i>V</i> <u>Avenue Ba</u>	lto, Md	21215 Approximate
	Physician /Medical Examiner	er	2 a. P. rt1. Enter the disease, or compock, or heart failure. List only of the diate Cause (Final sease or condition rulting in death)  Sequentially list conditions, if any, leading to immediate	a. Ov D Due to (or as	a consequence of):		ease			Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examln	Cause (Disease or injury that inflated events resulting in death) Last	c.  Due to (or as	a consequence of):					
.O. Box 6	The law requires that the death certificate has been signed by the attending bit age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
rds, P	quires that n signed I uld be det	by	Part II. Other significant conditions of	ntributing to death to		nderlying cause given	in Part I.			the cause of death?
Vital Records,	e law require has been si ge 2 should b	Completed	Chronic Rena	1 tallur	e			24a. Was an autopsy performed	i?   death?	utopsy findings available completion of cause of
la	G 77	e Co	25. Was case referred to medical	novesier	D/		26 Place of Death	1 ☐ Yes 2 ☑ (Check only one)	No 1 ☐ Yes	2 12 No
of	ding Phys	To B	avaminar?	Hospital: 1	ent 2 ER/Outpatier ury 28b. Time o lnjury	other f 28c. Injury a Work?	4 ☐ Nursing Hor	ne 5 Residence 28d. Describe how		ocify)
Division	al or Attandi s after death. Il Diractor: A od in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of In	jury - At home, farm, st tc. (Specify)	reet, factory, office		28f. Location (Stree City or Town, S	t and Number or R tate)	ural Route Number,
	To the Hospital or Attano within 24 hours after death To the Funeral Director: completely filled in by the	Medical (	29a. Certifier 1 Certifying Phyone) 2 Medical Exem	vsician: To the best iner: On the basis of and manner st	of my knowledge, deat of examination and/or in tated.	h occurred at the time vestigation, in my opi	e, date and place, a nion, death occurre	and due to the caus ed at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within 2 To tha comple	Σ	29b. Signature and title of certifier  Seen Min	- MD		29c. License	58959		Date signed (Mon	
	5		30. Name and address of person who of Jolene Brown, MD	ompleted cause of	death (Item 23a) (Type, YM Green	Print) Sheet	Bulhmer	e MD	21201	
	Sta Regist	-9.0	31. Date filed (Month, Day, Year)  M A V 2 0 20	10.	rar's Signature	order				

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and N  1 - State Registrar Certificate of Death	lental Hy	giene Reg. No. 20	05		023
	Physicia		1. Decedent's Name (First, Middle, Last) William T. Dutton	2. Date of De Month 1	-	Year	3. Time of E	Death M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Center  4b. City, Town, or Location of Death Bel Air		4c. County Har	of Death ford		
I	Funeral Director		5. Social Security Number 6. Sex 1 Months Days Hours Min. 1 M 2 F 81	8. Date of Bir (Month, Da Aug.	th ay, Year) 5, 1923		lace (State or try) yland	Foreign
	yland how		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location			10	0d. Inside City	
	Be-f sl	Director	Md. Harford Abingdon		10g. Citizen of V		1 Tes	2 <sub>2</sub> No
	3e or 3		10e. Street and Number 3103 Cardinal Way, No. D 21009			S.A.	пут	
٥	d within 72 hours after death with the Maryland Jison. Ir than "neturel", or Items 23e or 28e-f show The Modreal Examilier must be notified at	/ Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Never Married  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes, Specify Cuban, Mexican, Puerto  1 ☐ Yes, Give  1 ☐ Yes, 2 ☐ No	ecify Yes or No Rican, etc.)	14. Race Blac Specify	e - America k, White, e		
5-0036	hours	ed by	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Bu	***		
212	ithin 72 ie. ian "ne	Completed	(Specify only highest grade completed)  (Give kind of work done during most of work life. DO NOT use retired)	ring	firefig (Baltimo	hting	g	
d 21	Hygi Hygi ther	e Cor	12 years 17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle	<u> </u>			
<u>Ilan</u>	ed ital	To Be	unknown unkno	wn				
Maryland	s 1 and 2 should f Health and Men item 27 is marke other traumetic		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and Number or Rur</i>		-		Code)	
	s 1 and 2 f Health item 27 other tra	1	comptany cramatony or other place	Date	20c. Location -		wn, State	
altımore,	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other ance.		'4 □ Donation 5 □ Other (Specify) Bayview Crematory 5/19	/2005	Baltim	ore,	Md.	
Balt	permit. Depart Import eny inj		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Schimunek Funeral.	Home o	f Bel Ai			
	7		23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	oad, Be or respiratory a	1 Air, M	d. 21	1 0 1 4 Approximate Interval Betw	/een
	Pnysician	6 1	Immediate Cause (Final disease or condition resulting in death)  a. Aspiration In eumeni	a.,			Onset and Do	eath
	/Medical Examiner		Due to (or as a consequence of):					
7	p ii q	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
V	be executed ician and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last C.  Due to (or as a consequence of):					
8760		dical E	d					
O. Box 68	The law requires that the death certificate te has been signed by the attending physoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 5 ☐ Other (specify) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		23d. Dat Mor	e of delive		ear
rds, P.	quires that n signed b ıld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Emphysema, Parkinson's Disease	23e. Did	tobacco use conti Yes 2 □ No		ne cause of de ably 4 □Ur	
Vital Records,	The taw requira ate has been sin page 2 should t	Completed	Atheroscherosis (Generalized), Acute Menal Failure	24a. Was auto perfe 1 Yes	ormed?	Were autor prior to con death?	psy findings at appletion of car	vailable use of
/Ita		Be	25. Was case referred to medical asymmetrs 26. Place of Deat	h (Check only	one)			
ö	Physi r this c sral dire	.: To	Hospital: 1 Impatient 2 Impatient 3 DOA Other: 4 Nursing Ho  27. Manner Death 28a. Date of Injury 28b. Time of 28c. Injury at		dence 6 Other		')	
ion	ttending P death. ctor: After I y the funera	atlo	1 ⊟Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No					
Division	al or Attence	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		Street and Numb wn, State)	ar or Rurai	i Route Numb	er,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.					
	To th To th comp	Me	29b. Signature and title of certifier  29c. License number  D 3 5 0/2		29d. Date signed			
	6		30. Name and address of pers I who completed cause of death (Item 23a) (Type, Print)  J. Revin Lywin Mb 2 North Ave.	1	•			14
	Sta Registr		31. Date filed (Month, Day, Year)  32. Degistrar's Signature			,		
	Licălati	4	MAY 2 0 2005 Brave B Brave					

			For State Registrar	State of M	aryland		rtment tificate				R	eg. No.	2005	17024
	Physicia /Medic Examin	al	Decedent's Name (First, Middle,  Leonard  4a. Facility Name (If not institution,	Elmer	)	Dixon	4b. City, To	own, or L	ocation of	N	Month 1ay 8,	2005	Year County of Death	3. Time of Death 6:10 PM
	Funeral Director		Crofton Conva	lescent Cen		st birthday) Yrs.	Cro	ofto		4 Hrs. 8.	Date of Birth (Month, Day		9. Birth Cou 22 Balt	ndel  place (State or Foreign intry) imore, MD
nd 21215-0036	ilied within 72 hours after death with the Maryland Hygiene. thar than "natural", or Items 23c or 28a-f show int, I're M-dical Examinar must be notified at	Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  MD  Anne  10e. Street and Number  2131 Davidson  11. Marital Status  1 Never Married 2 Marrie  3 M Widowed 4 Divorced  (Specify only highest  Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, L.)	12. Was Decedent Amed Forces 1 K1Yes 2 If Yes, Give Year or Dates: s Education grade completed)  College (1-4or	C1 Ever in U.S No1/6/ 10/12	43 /45 16a. Deced (Give life. L	10f. Zip C	1114 nt of His y Cuban y Cuban No Occupat done du retired)	Specify: ion tring most of	in? (Specifi Puerto Ric of working	y Yes or No- can, etc.)	U. S  14  S  16b. Kinc	en of What Cou	10d. Inside City Limits 1 □ Yes 2 ☒ No untry? ican Indian, , etc.
e, Maryland	1 and 2 should Health and Men am 27 Is marks ther traumatic	To	Thomas Howard  19a. Informant's Name/Relationsh Saundra Dixon  20a. Method of Disposition	ip (Type, Print)	20b. Pfa	104 W	lesteri	n Po	inte	or Rural F	Columb	; City or i	Town, State, Zi SC 292	29
Baltimore,	permit. Pages Department of t Important: If its any injury or or		1 Burial 2 Cremation 1 Donation 5 Other (Sp	ecify)	Ce.	ropoli - 22	tan Ci	<i>er place,</i> rema Address e So	tory	7	/05	Alex	kandria	
68760,	death certificate be executed  Wedical  Examiner  A for use as the burial-fransit	icai Examiner	23a. Part1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	line. Infa s a consequenary A s a conseque	rct De ence of): theros ence of):	er the mode	a	, such as c	ardiac or r	espiratory arr	est,		Approximate Interval Between Onset and Death Years Years
O. Box 68		Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant; 9 Unknown	2 Fetal	death 3	Ectopic pred Other (spec					23	d. Date of deliment	very Day Year
Records, P.	v requires been sign should be	Completed by Ph	Part II. Other significant condition  Carcinoma of B  Anemia		but not resu	Iting in the u	nderlying cau	nse giver	n in Part I.		23e. Did to	es 2 🔀	No 3 ☐ Pro	the cause of death?  bably 4 Unknown  topsy findings available ompletion of cause of
Division of Vital Re	ding Physician: h. After this certifica funeral director,	Certification: To Be Com	25. Was case referred to medical examiner?  1  Yes	ation	jury ay Year)	ER/Outpatier 28b. Time o Injury	f 28	Other	4 XNur	sing Home 28	perform 1 Yes  Check only or 5 Resided. Describe here	ned? 2 V No ee) ence 6	death? 1 Yes	2□ No
Divi	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical Certific	4 Homicide determi	ned 286. Place of I	etc. (Specify,	vledge, deat		t the time		place, an	City or Tow	n, State) ause(s) a	ınd manner as	
	Toth within Toth	Me	29b. Signature and title of certifier  30. Name and address of person	Sh c		291 23a) (Type.	4/) D	License			2		signed (Month	
ı	\ \( \begin{align*} \	ate	Rakesh Aurora, M  31. Date filed (Month, Day, Year)  MAY 2 (	D 14300 Ga		Fox I	Lane	Bowi	e, MI	20	715			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10AM Month Year obest bucan 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Essex

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Aug. 11, 1 Baltimore Riverview Care Center 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Months M 2□F 73 1931 216-28-3904 Ohio Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Baltimore 1 ☐ Yes 2 ☐ No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Mingo Lane U.S.A. 21221 12. Was Decedent Ever in U.S. Armed Forces?
1 □Yes 250No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes ♣ No Specify: Specify: 3℃Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Construction Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edna Elizabeth Cawley Larry Lynch Duncan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Reynolds (Daughter) 147 Riverside Road, Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Gardens Of Faith May 21, 2005 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home, 21. Signature of Funeral Service Licensee Bruzdzínski Funeral Home, P.A. Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Do the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should be a failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat ause (Final disease / condition resulting in death) Due to (or as a consequence of): inder Z Why Due to (or as a consequence of). Due to (or as a consequence of): 23d. Date of delivery 23b. Was decedent pregnant Year

**Physician** /Medical Examiner

burial-transit

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detached for

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funeral director

the

filled in by

After

after death.

within 24 hours a To the Funerel C

or Attending

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has page 2

The law requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

Examiner

Be Completed by Physician/Medical

Certification: To

Medical

Physician

/Medical

Examiner

10a State

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

item 27 is marked other then "naturel", or items 23a or 28e-f show other treumstic event, the Medical Examinat must be routiled at

al Hygiene.

Mental

f Health i

permit. Pages 1 Department of H Important: If ite any injury or ot once.

Completed by Funeral Director

Be

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9 Unknown

Month Day

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. over rouge decoase

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 → Unknown

6 renay

24a. Was an autopsy performe 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 2 No

25. Was base referred to medical examiner? 1 ☐ Yes 2 ☐ No

in the past 12 months? 1 ☐ Yes 2 ☐ No

9 Unknown

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

2 🗆 No

27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 - Homicide

5 Pending investigation 6 ☐ Could not be

1 Yes 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)

28l. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one) The cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier Mused (evans) 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) 0 Michael Schwartz,

31. Date liled (Month, Day, Year)

MAY 2 0 2005

7310 Ritchie Highway, Glen Burnie, Md. 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( 1 - State Registrement ITEM #12 PER FH G844 6/01/05 JH 2. Date of Death Time of Death Month Halver B. Dash **Physician** ma 6220A M 2005 /Medical a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death County of Death Examiner en myst Armax USVITO Hours Min. 8. Date of Birth (Month, Day, Year) 1-23-1923 9. Birthplace (State or Foreign Country) Maryland last birthday) 6. Sex 7. Age (In yrs. 82 Security Number - 16 - 7723 **Funeral** Days Months 1\XM 2□ F Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State itam 27 is marked other than "natural", or Itams 23a or 28e-f show other traumatic avant, if a Madical Examiner must be notified at 1 ☐ Yes 2 ZNo Director Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 217 N. Hammonds Ferry Rd. 21090 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give 5 122344 Year or Dates: 122344 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) 8th Truck Driver Freight 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Adam Dash Pearl Hommerbocker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If itam 27 is any injury or other tra once. Mary E. Dash/ Wife 217 N. Hammonds Ferry Rd. Linthicum MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X2-Burial 2 ☐ Cremation 3 ☐ Removal from State Lakeview Memorial Park 5-19-2005 Sykesville, MD ign dure of Funeral Sondice Livensee 22.Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne MD 21227 23a. Part 1. Enter the disease or complications that caused the dishock, or heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause fulseass or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 4 ☐ Pregnant at time of death the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an certificate has autopsy 1 Yes 2 No Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27, Manner of Death 28d. Describe how injury occurred Certification: Division 1 Alatural 5 Pending 2 🗌 No death. 1 Yes investigation 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) n 24 hours after d 4 🔲 Homicide 29a. Certifier 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29d. Date/signed (Month, Day, Year) 29b. Signature and title of certifie 2005 who completed cause of death (Item 23a) (Type, Print 30. Name and address of perso BOA V 0

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Mor.

200

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

						,	(	Certificate o	f Death	1	Reg. No.2 0	05	17	027
	Disconing		1. Decedent's Name (First, Mi	ddle, Les						2. Dete of Dee Month	eth Dev	Year	3. Time o	f Death
1	Physiciar /Medica	-	PATRICIA	Α.	EI	LIIGSO	Ŋ			MAY 16			7:30	) AM
	Examine	•	4a Fecility Neme (If not institu	tion, give	street end nur	n <i>ber)</i>			4b. City, Town, or L	ocation of Deeth	4c. County	of Death		
			1108 ROSEDA			_			ROSED				IMORE	
	Funeral Director		5. Social Security Number 212–62–8482	6. Se	ex □M2√⊋F	7. Age (In yi		day) If Under 1 Yearns. Day		8. Date of Birt (Month, Day 6-1-19	h у, <i>Үөаг)</i> 953		place (State of htry) ARYLAN	
	pue &	-	Usuel Residence of Decedent 10a. Stete 10b. Cou	ntv		10c.	City Town	or Location				1	0d. Inside C	Lity Limits
	show	5		•	MORE		o.i.j, 10iii.	or countries	ROSE	DAT.F				2√2 No
	vith the Ma	8	10e. Street end Number					10f. Zip Code			10g. Citizen of \	Mhot Cour		
	with o	5						Tot. Zip Code						
	of the country of the	2	1108 ROSED	ALE	AVENUE 12. Was Dece	dent Ever in	II S	13 Was Decedent o	21237 Hispanic Origin? (Sr	necify Yes or No.	U 14 Bac	S.A.	an Indian	
_	iten iten	5	1 Name Status  1 Name Status  1 Name Status	arried	Armed Fo	rces?	0,0.	If Yes, specify Co	f Hispanic Origin? (Sp ban, Mexican, Puerto	Rican, etc.)	Blac	ck, White,		
Maryland 21215-0020	Irs a	2	3 ☐ Widowed 4 ☐ Divorce	i i	1 ☐ Yes If Yes, Giv Year or D	ates:		1 ☐ Yes 2 [X]N	o Specify:		Specify	WHIT	ľE	
5-	72 h	Completed	15. Deced (Specify only hig	lent's Edi	ucation de com <i>pleted)</i>		1	Decedent's Usual Occ Give kind of work dor	e during most of work	king	16b. Kind of B	usiness/Ind	dustry	
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7	ygiei r, th		10					HOMEMA		45			HOME	
and and	d off	5	17. Father's Name (First, Midd		TTGGGA				18. Mother's Nam					
3	d 2 should be filed within the end Mental Hygiene. 7 is marked other than traumatic event, the Mar	2	JOHN		LIGSON				CATHER		(TRATT		-	
Jai	2 sh end ia m		19a. Informant's Name/Relation			-		Mailing Address (Stre						
ď.	ges 1 and 2 t of Health If item 27 i or other tra	-	SHANNON ELLIG	SON/	DAUGHI			108 ROSEDA  Disposition (Name of	LE AVENUE	ROSED	ALE, MD		1237	
0	8 = 5		20a. Method of Disposition 1 → Buriel 2 ☐ Cremetic	n 3 🗆	Removal from		cemetery	crematory or other p	lace)	Date	20c. Location -	City or 10	own, State	
ţ	Pag tment tant: If		4 ☐ Donetion 5 ☐ Other			Н	olly	Hill Cemet	ery	5-20-05	BALTIM	ORE,	MD	
Baltimore,	permit. Pa Departmen important: any Injury pnce.	l	21. Signature of Funeral Servi	ce Licens	S00			1211 CHES	ress of Facility CVA	ACH/ROSE E ROS	DALE FU EDSALE,	NERAI MD	HOME 2123	7
		+	23a. Part1. Enter the disease shock, or heart failure.	or comp	dications that c	aused the de	ath. Do no	ot enter the mode of d	ying, such as cardiac	or respiratory ar	rest,		Approximation	te
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	/Medical		Immediate Ceuse (Final disease or condition		. HET	יזייערייע	T.I.IT.7\	R CANCER W	TMU VCCTU	CTDD	HOCTC	:		
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٧	ficeta be axecuted in the physician and the bunal-transit		Sequentially list conditions,	ſ	D			nsequence on.				1		
8	oe axo	ì	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	"	DIA	BETES	MELL:	ITUS TYPE	I			1	YR	
68760,	ficeta be physicials the bur	3	that initiated events resulting in death) Last	•	U	Due to	(or as a co	nsequence of):						
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Вох	at the death cert d by the ettendin etached for usa											- !		
o.	the e		Part II. Other eignificant cond	itions co	ntributing to de	ath but not re	esulting in t	he underlying cause	given in Part I.	23b. Did t	obacco use co			
Δ.			HYPONATREMIA,	HYP	OALBUMI	UEMIA,	OBE	SITY, HEPA	TITIS C	101	Yes 2. ZXNo	3 Prot	bably 4	Unknown
Records,	i signe									24a. Was a	an autoney	24h W	ere autopsy	findings
Ö	The law require sate has been single pege 2 should	5	ANEMIA								rmed?	ava	ailable prior i	to
3ec	has the second								· · ·			of	death?	
al										1 🗆 Y	′es 2 ∏XNo	1	Yes 2√	No
Vital	Physician: T this certificat ral diractor, p		25. Was case referred to med examiner?	-	Hospital:			_ 10	26. Place of Deal					
o	A SED F	- ⊦	1 ☐ Yes 2 ☐ No 27. Menner of Death		1	·	ER/Outp	ALIGIT SEL DOA	4 Unursing no	ome 5 Resid			HOS	PICE_
Z	fing After	5	1 Naturel 5 ☐ Pen		28e. Dete o	h, Dey Year)		ury W	ork? □Yes 2□No	ZOG. Describe i	low injury occur	90		
Si	Attending or death. ector: After by tha fune	3	3 ☐ Suicide 6 ☐ Cou	stigation Id not be	28a Place	of Injune - At	home form	n, street, factory, offic		28f. Location (S	Street and Numb	er or Rurs	I Route Num	her
Division	tal or Attending P is after death.  By Director: After the in by the funers  Contification:		4 ☐ Homicide dete	mined	buildir	ng, etc. (Spe	cify)	ii, street, lactory, onic	9	City or Tow		or or ribra	TODIO NON	ibor,
	Hospital 24 hours Funeral Italy filled		29a. Certifier 1 <b>☑ Certif</b>	vina Phy	sician: To the	hest of my ki	nowledge.	death occurred at the	time, date and place	and due to the o	cause(s) and ma	nner as s	tated	
	he Hospi in 24 hou he Funer plataly fill	2		ai Exami	inar: On the ba	sis of exami	nation and/	or investigation, in my	opinion, death occur	red at the time, o	date and place,	and due to	the cause(s	3)
	To the Hospital or A within 24 hours atter To the Funeral Dire complataly filled in b Medical Carti		29b. Signature end title of cert	fier	1. 1	1	1- 1	29c. Lice	nse number		29d. Date signe	d (Month,	Day, Yeer)	
	-> P O		> //llen	1	ull	41	ND		D54749		MAY 19	). 2n	05	
	^	-	30. Name and eddress of pers	on who o	ompleted caus	e of deeth /It.	em 23e) (T					, 20		
	<i>b</i>							ROSS ROAD	Ватлтм	ORE, MD	2122	28		
()	State		ALLEN RETILY, 31. Date filed (Month Day, Ye	(ML)	32 R	egistrer's Sig	nature	M A MAD	mr z[/]	اللاء وساد	<u> </u>	, ,		
	Registrar		MAIZ	V ZUL	JO CE	BARO &	The Ass	2000						

DHMH 16 Rav 6/95

			1 - For State Registrar	State of Ma	ıryland /		artment of H rtificate of L		nd Mental Hy	/giene Reg. No.	2005	17	028
	Physici	an	1. Decedent's Name (First, Middle, Las						2. Date of D Month	eath Day	Year	3. Time of	
	/Medic		John Willia		ans				May 16			6:43	A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or		Death	4c. C	ounty of Death		
	Euparal		Masonic Homes  5. Social Security Number 6. Se	ex 7. Age	(In yrs. last bi	irthday)	Cockeys	If Under 2		irth	9. Birth	place (State o	r Foreign
	Funeral Director			<u>™</u> 2□ F	93	Yrs.	Months Days	Hours	Min. (Month, D May 26	ay, Year) 1911	l Mary	land	93
	p ,		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	m or Lo	ecation					10d. Inside Cit	ty 1 imite
	lanyla show	ŏ	MD N/A				e City					1 (XYes	
	28a-f	ect	10e. Street and Number		Daici		10f. Zip Code			10a. Citize	n of What Cou	ntry?	
	3a or	0	1404 Inverness Av	zenue –			21230				SA		
	filed within 72 hours after death with the Maryland Hygiene. ther than "neturel", or ttems 23a or 28a-f show ther than "neturel", or ttems 23a or 28a-f show int, the Medical Evanting must be notified at	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?		13.	Was Decedent of Hi	spanic Orig	in? (Specify Yes or N Puerto Rican, etc.)	0- 14	Race - Ameri Black, White,		
9	after or ite	F	1 Never Married 2 Married	1 Tyyes 2 N	1942 1946	-	1 ☐ Yes 2 ☐ No	Specify:	Tuesto ritoan, etc.)	s		ite	
8	urel',	Completed by	3 Widowed 4 Divorced	Year or Dates:	1310		death Havel Occurs				of Business/In		
5	n 72	jete	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	dent's Usual Occupa kind of work done o DO NOT use retired	luring most )	of working	160. Kind	or business/ir	idustry	
212	iene.	mo de	Elementary/Secondary (0-12)	College (1-4or 5	+}		ger			M	usic		
שַׁכ	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, the Ms	Be C	17. Father's Name (First, Middle, Last)					18. Mother	's Name (First, Middle	e, Maiden Si	umame)		
<u>Jai</u>	should be and Mental s marked c umatic eve	2	William Emory Eva						ie Barbara				
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. item 27 is marked other than "neturel", or items 23a or 28a-f show item 27 is marked other than "neturel", or items 23a or 28a-f show other treumstic event, it is Medical Examiner must be notified at		19a. Informant's Name/Relationship (1				•		or Rural Route Numi		own, State, Zij	Code)	
	of Health item 27		Nancy Evans (daug	ghter)					ston, MD 2	_	ition - City or T	own State	
Baltimore,	Pages nent of h int: If ite iry or of		1 ABurial 2 ☐ Cremation 3 ☐	Removal from State			osition (Name of matory or other place					omi, otate	
ᆵ	permit. Pages Department of Importent: If i any injury or once.	1	* 4 ☐ Donation 5 ☐ Othe (Specify 21. Signature of Funer   Section Lice		Loudor		rk Cemete  Name and Addres		5/19/2005 Loudon I		imore uneral	Home	
Ba	permit. Departn Importe any injt		Jamo Vima	wh.					ve. Baltir				
8760, <	hysician and hysician and hysician and hysician and hybridaturansit hybridaturansi hybridaturansi hybridaturansi hybridaturans	cai Examiner	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a b. Due to (or as a c.	S tan a consequence a consequence	of):	Alzhan	mvi	's Denei	tn		Interval Betwonset and D	
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 🗌 Fetal déat		⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>			23	d. Date of deliv Month	*	/ear
Э, P.	res that igned b be deta	by PI	Part II. Other significant conditions of	ontributing to death bu	ut not resulting	in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use	contribute to t		e)
Records,	w require been sig should b	ted	Lancer y Prista	te, corp	1 /ma	mi	w,	-	1	Yes 2	No 3∏Prol	bably 4	Inknown
ecc	law r has be	Completed							24a. Wa	ODSV		opsy findings a impletion of ca	available ause of
E B	: The	S						.,_	pen 1 ☐ Yes	formed? 2.2 No	death? 1 🗌 Yes	2. No	
of Vital	Physician: The law this certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:			othe		of Death (Check only				
o	Phys r this ral di	5.	1 ☐ Yes 2 ☑No 27. Manner of Death	1 ☐ Inpatie 28a. Date of Injur (Month, Day	and the second s	utpatier Time o	ii 3 DOA	4/201901	sing Home 5 Res			<b>(y</b> )	
on	Attending F r death. ector: After by the funera	tior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		(Year)	Injury		(? Yes 2 □ N	lo				
Division	I or Attendi after death. Director: A in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury - At home, f c. (Specify)	arm, st	reet, factory, office			(Street and i	Number or Run	al Route Numi	ber,
	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edical C		ysician: To the best of niner: On the basis of and manner sta	examination a								)
	To the To the To the Complex c	Me	29b. Signature and title of certifier				29c. License	number		29d. Date	signed (Month,	Day, Year)	,-'
			P.t. Til	rests, un	o -		Da	146 y		5/1	16105		
	541		30. Name and address of person who R&Bart t. LIR	completed cause of d	eath (Item 23a)	(Type,	Print) Back St	- 12	alto, Ni	4 Z	1224		
	Sta	ite	31. Date filed (Month, Day, Year)	22. Registra	ar's Signature	fre	Mes				-/		
	Regist	rar	MAY 2 0 200	15 Ellare	10 1	4							

			State of Manuford / Department of Health and	•		
			State of Maryland / Department of Health and	Mentai Hygiei	PANE	17000
			Registrar Continuate of Death	Reg.	N6:- U U U	111029
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death	Day Year	3. Time of Death
	/Medic		Carl Schwarz Cmmel.	May 1	8 05	3 AM
	Examin		4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Dea	ath /	4c. County of Deat	n _
			LORIAN (a) KULUSIDE BOLGANI	6	HARFO	ed
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Jir Months   Days   Hours   Mir		9. Birti	nplace (State or Foreign untry)
	Director		213-20-5138 10M 20F 82 Yrs. Months Days Hours Mir	3-10-2	3 MA	RYLAND
	P _		Usual Residence of Decedent			
	urylar thow	L	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	r 28a-f show	cto	MD Hastord Fallston			1 ☐ Yes 2 No
	death with the Maryland rms 23a or 28a-f show r must be notified at	Funeral Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Co	untry?
	ours after death with al', or Items 23a or Examinar must be	a	3236 Canterbury Lang. 21047		1)SA	
		ner	11. Marital Status  12. Was Decedent Ever in U.S. Almed Forces?  13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No-	14. Race - Ame Black, White	
9	or Ite		1 □ Never Married 2 1 Married 1 □ Yes 2 1 No Specify:	nto ritouri, dio.,		, etc.
8		l by	3 Widowed 4 Divorced Year or Dates:		Specify: W	rite.
5-0	within 72 hours after ene. than "natural", or Ite tte Mid Fall Exicition	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of with the complete of t	orking 16b.	Kind of Business/	ndustry
2	thin an	npf	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of wellife. DO NOT use retired)	/	3 /	
2	e filed withir Il Hygiene. other than vent, the M	Son	11 TRUCK Driver	(	enert	
B	al Hy loth veniven	Be	17. Father's Name (First, Middle, Last)  18. Mother's Na	ame (First, Middle, Maid	len Sumame)	
<u> a</u>	ould be Mental sarked c	10	Henry t. cmmel (arol.	ine Anna	Schu	IRZ.
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hc n of Health and Mental Hygiene. If item 27 Is marked other than "nature or other traumatic event, the Modical		19a. Informant's Na e/Relationship (Type, Print)  19b. Mailing Addless (Street and Number or F	Rural Route Number, Cit	y or Town, State, Z	ip Code)
	and 2 ealth n 27 I		Ella Mae Emmel-wife, 3236 Cauterbury	D. Fallst	NMD	4047
re	item item		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c.	Location - City or	Town, State
Baltimore,	permit. Pages 1 and 1 Department of Health Important: If item 27 any injury or other tr once.		I Dulial 2 Micialitation 3 Diramovat nom State	5-19-15 E	APEST I	4111. MM
Ħ	permit. Pa Departmer Important any injury		*4 □ Donation 5 □ Other (Specify) FVADSTUBE PACHAPET - BOLAIR  21. Signature of Funeral Service Licensee 22. Name and Address of Facility	DEST HILL	mpall	157
ä	permit Depart Import any in		Kimberly ( Bariotay EVANSFORERACCHI	DOEL-BELDE	0 3NY11	HOT WE
	7000		23a. Part. Enter the disease, if complicitions that caus ut the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only on- cluse on each line	ac or respiratory arrest,	re jorea	Approximate
			shock, or heart failure. List only on-a cruse on each line.  Immediate Cause (Final		1	Onset and Death
	Physician /Medical		disease or condition resulting in death)	ire		al least on
-	Examiner		Due to (or as a consequence or):			Near
		60	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
Y	ted	nin	cause. Enter Underlying Cause (Disease or injury		]	
7	xecu and al-tra	Examiner	that initiated events resulting in death) Last   C  Due to (or as a consequence of):			
760	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	calE				
687	physic the		d			
×	certifica Iding ph	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		22.2.	
Box	ath c	ian	in the past 12 months?		23d. Date of deli	Day Year
	the a	/sic	1 Yes 2 No 9 Unknown 5 Other (specify)			
P.0	requires that the death een signed by the atter hould be detached for u		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did tobacc	a use contribute to	the cause of death?
Ś	es De	Completed by	Description of the distribution of the distrib			bably 4 Dunknown
9	v requir been s should	ted	ravers relitus Intellitus	1 103	2 3 110	Dably 4 Donkhown
ec	aw 1s b	ple	Dementic	24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
<b>E</b>		Con	parter) ( a	performed?		2 10
Vital Records,	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	eath (Check only one)		
of V		2	Hospital:	Home 5 🗆 Residence	6 □Other (Spec	ify)
0	iling Phys After this funeral di		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28c. Injury at Work?	28d. Describe how in	jury occurred	
<u>.</u>	ath. or: Ai	atle	2 Accident investigation M 1 Yes 2 No			
Division	Atte	tific	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, Sta	and Number or Ru	al Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical Certification:			,	
	hour hour uner ly fill	cal	29a. Certifier  (Check only   Check only   C	ce, and due to the cause	(s) and manner as	stated.
	n 24 n 24 he Fi	edic	(Check only one)  2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	curred at the time, date a	and place, and due	to the cause(s)
	# E E E	Σ	29b. Signature and title of certifier 29c. License number	29d. [	Date signed (Month	, Day, Year)
	5 ₹ 5 8					
	Z 2 2 8		Manufort Diatez	Ma	410 7	DOT
	<b>√</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Ma	418,2	005
	T W T S		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  **Chuel M. Vaam M.D. Slaw S	treet A	y 8, 2 berdee	005 Marylan
	Sta	te	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Source  31. Date filed (Menth, Day, Year)  32. Degistrar's Signature	treet A	berdee	olo Maylan

DHMH 17 Rev 1/2001

ENMEL

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		1 - State of Maryla Registrar	•	artment of Health and M		ene g. No.2 0 0 5	17030		
Physici	an	Decedent's Name (First, Middle, Last)     ERNEST NATALE	FERR.	ARI, JR.	2. Date of Death Month 05	Day Year 15 2005	3. Time of Death 9:55 P M		
/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Deat	h		
		MARINER HEALTH OF FOREST HILI		FOREST HILL		HARFORI			
Funeral Director		5. Social Security Number    1	s. last birthday) Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Jan. 17	Year) Co	nplace (State or Foreign untry) 1ryland		
yland how		10a. State 10b. County 10c. C	City, Town or Lo				10d. Inside City Limits		
Ba-1 •	Director	Md. Harford	Bel	l Air			1 X Yes 2 □ No		
with the or 2	Dire	10e. Street and Number		10f. Zip Code 21014	10	lg. Citizen of What Co U.S.A.	untry?		
ms 23	Funeral	304 Hemingway Drive  11. Marital Status 12. Was Decedent Ever in	U.S. 13.	Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ame			
Deficient of the property of the process of the many and permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "natural", or Items 23e or 28e-f show apply injury or other traumatic event, the Medical Examinating notified at ance.	þ	Armed Forces?  1 ☐ Never Married 2 ☐ Married  1 ☐ Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No Specify:	Hican, etc.)	Specify: wh			
72 hc	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of work	king 1	6b. Kind of Business/	ndustry		
within than the Ma	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12 years		<i>DO NOT use retired)</i> naser in Logistics	Admin.	Federal g	overnment		
e filed al Hygi other vent, I	BeC	17. Father's Name (First, Middle, Last)		[	e (First, Middle, M				
yidi ould b Menta markad	To	Ernest Natale Ferrari, Sr.			Josephin				
i, IVICII and 2 sh ealth and n 27 is m	- 3	19a. Informant's Name/Relationship ( <i>Type, Print</i> )  Carl B. Ponicki/brother		ng Address (Street and Number or Ru Hemingway Drive,					
of Hear		20a. Method of Disposition 20b.	Place of Dispo	osition (Name of matory or other place)	Date 2	Oc. Location - City or	Town, State		
mit. Pages mit. Pages partment of I portant; if Its y injury or o		`4 □Donation 5 □Other (Specify) St			9/2005	Baltimore,	Md.		
Dennit. Departr Importa		21. Signature of Funeral Service Licensee		2. Name and Address of Facility Schimunek Funeral 610 U MacPheil R	Home of	Bel Air, I	nc.		
Physician /Medical Examiner		23a. art1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a lonse)	eral	ter the mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death		
cate be executed physicien and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  b. Oue to (or as a some cause consistency).							
I necolds, F.O. BOX 50/00.  The law requires that the death certificate be atensioned by the attending physicis aggle 2 should be detached for use as the but	Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No  9 □ Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year		
w requires that is been signed by should be detailed	by	Part II. Other significant conditions contributing to death but not re	esulting in the u	inderlying cause given in Part I.		acco use contribute to	the cause of death?		
The law rec	Completed				24a. Was an autopsy perform	prior to o	topsy findings available completion of cause of		
VICAL Iclan; 1 Certifical ector, p	Bec	25. Was case referred to medical examiner?			th (Check only one	-			
VISION OF VITAL Attending Physician; r death. ector; After this certifical by the funeral director;	2		ER/Outpatie		ome 5 Resider	nce 6 Other (Spec	cify)		
rding th.: After funer	tlon	1 Matural 5 Pending (Month, Day Year) 2 Accident investigation	Injury	of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	200. 2000/120 110	williary boodings			
al or Atter after dea Director d in by the	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined 28e.)	home, farm, st	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,		
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely illed in by the funeral director, page 2	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my king one in the basis of examiner: On the basis of examiner and manner stated.	nowledge, deat nation and/or in	th occurred at the time, date and place exestigation, in my opinion, death occu	and due to the car rred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)		
To th withir To th comp	Me	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Mont)			
ıĎ	113	30. Name and address of person who completed cause of death (It.				1ay 16,	2005		
IV				BERDEEN, MD 2100					
Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Sig	Speed	EI .					

DHMH 17 Rev 1/2001

		1	For State Registrar	State of Maryland		artment of F			ene 0 0	5 17031
	Physicia		1. Decedent's Name (First, Middle, Last,	1011		WITE	NO	2. Date of Death Month	Day Ye	3. Time of Death
	/Medic	al -	4a. Facility Name (If not institution, give	etraet and number)		4b. City, Town, o		MHY	4c. County of D	Death
	Examin	er	Howard County Ger	eral Hospital		Columb:			Howar	
	Funeral Director		213 10 0015	7. Age (In yrs. Id M 2 F 93	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year 1911 9.	Birthplace (State or Foreign Maryland
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City	Town or Lo	ocation				10d. Inside City Limits
	Mary P-1 sh	tor	Maryland Howard	Co.	rumb1a	l.				1 ☐ Yes 2 🂢 No
	h with the 23a or 28 at Le noi	Funeral Director	10e. Street and Number 6336 Cedar Lane	#376		10f. Zip Code 21044		10	U.S.A	-
36	be filed within 72 hours after death with the Maryland Hygiene. ad other than "netural", or items 23a or 28e-f show event, the Madical Examiner must be notified at	oy Funer	11. Marital Status  1 □ Never Married ②【 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	-	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2∑ No	lispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		American Indian, White, etc. White
5	2 hou	ted	15. Decedent's Edu	ication	16a. Dece	dent's Usual Occup	ation	orking	16b. Kind of Busin	ess/Industry
215	within 7 ene. than "n	Completed by	(Specify only highest grad	0.11 (4.4 - 5.)	///////////////////////////Printe	kind of work done DO NOT use retired	during most of wi	Jiking	Printin	g
<u>ام</u>	be filed within ntal Hygiene. od other than event, Ine Ma	Be	17. Father's Name (First, Middle, Last) John Fulton					ame (First, Middle, A tasia Hop	Maiden Sumame)	
ryla	2 should be and Mental is marked o aumatic eve	၉	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ng Address (Street	and Number or F	Rural Route Number,	City or Town, Sta	te, Zip Code)
Ma	alth ar		Mark L. Fulton, S	Sr. / son	609	Holly R	idge Rd.		Park, M	
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic e once.	i	20a. Method of Disposition	Removal from State	emetery, cre	osition (Name of matory or other place Park Ceme		Date 5	20c. Location - City Woodlaw	
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licens	2	1	.328 Sulpl	hur Spri	ome, Inc. ng Rd. A		MD. 21227
	Prrysician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. A CULTO	1148	ter the mode of dyin	ng, such as cardi	ac or respiratory arre	tion	Approximate Interval Between Onset and Death
	Examiner		ſ	Due to (or as a consequ	ience off.			V		
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a sur sequ	rente of).					
	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):					
8760,	e be e sician b buria	calE	l	d.						
9	tificate ng phy as the		IC FCHAIC	-						10.
.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date o Month	f delivery Day Year
<u>α</u>	uires that t signed by lid be detac	þ	Part II. Other significant conditions co	ntributing to death but not rest	ulting in the o	underlying cause giv	ven in Part I.			te to the cause of death?
Records,	<b>rsician:</b> The law requir s certificate has been si director, page 2 should I	Completed						24a. Was a autops perform	y prio ned? dea	re autopsy findings available r to completion of cause of th? Yes 2 \( \subseteq \) No
Vital		Be C	25. Was case referred to medical examiner?					eath (Check only on	(0)	
of V	al call	ဥ	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 2	ER/Outpatie	INT 3 DOA		Home 5 Reside	ance 6 Other owninjury occurred	(Specify)
on	ding After tune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wo	rk? ]Yes 2∐No		,,	
Division	or Attanding after death. Director: After	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, s	treet, factory, office		28f. Location (St City or Town	reet and Number ( n, State)	or Rural Route Number,
-	To the Hospital or Attani within 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier 12 Certifying Ph. (Check only one)	/sician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, dea tion and/or i	th occurred at the tinvestigation, in my	me, date and pla opinion, death oc	ce, and due to the courred at the time, d	ause(s) and mann ate and place, and	er as stated. I due to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	Hi Chan	M.T	29c. Licen:	se number	731	9d. Date signed ()	Month, Day, Year) 5 2005
	N		30. Name and address of person who	completed cause of death (Item	23a) (Type	Print) AB	€ DA	ALT	KHAN	MD21044
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 2 0 2005	32. Registrar's Signa	iture	(i)		- Will		

		State of Maryland / Der 1- State of Maryland / D	partment of Health and N 43,05/20/05dbb critificate of Death	Reg.  2. Date of Death	ne No. 2005	3. Time of Death
Physic /Med		STEVEN KENNETH FRUSH JR.		MAY 8,	2005 Year	2037 P M
Exami		4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL	4b. City, Town, or Location of Death BALTIMORE	]	4c. County of Death BALTIMORE	CITY
Funera Director		5 Speial Security Number 219-98-1953 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 24 Yrs.	// If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye January 2.	3,1981 BA	place (State or Foreign ptry) LTIMORE CO
Aaryland f show	o.	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or I   MARYLAND   BALTIMORE   LUTHER			1	0d. Inside City Limits 1 ☐ Yes 2 X No
h the h or 28a-	irect	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	ntry?
ath wit	rai D	1001 ADCOCK ROAD	21093		USA	
of 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It is marked other then "natural", or Items 23a or 28a-f show treumatic event, its Medical Evanifical must be notified at	by Funeral Directo	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent Ever in U.S. Armed Forces?  1	. Was Decedent of Hispanic Origin? (Sp tf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: WHI	etc.
"natur	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing 16b	. Kind of Business/In	dustry
d withir giene. r then	ф	Elementary/Secondary (0-12) College (1-4or 5+)	IAL ARTS INSTRUCTOR	₹ F	REEDON MAI	RTIAL ARTS
should be filed and Mental Hygic markad other matic event,	To Be C	17. Father's Name (First, Middle, Last) STEVEN KENNETH FRUSH SR.	18. Mother's Nam	e (First, Middle, Maid	den Sumame)	
12 sh hand 7 is m treum			ling Address (Street and Number or Rur ADCOCK ROAD, LUTH			Code)
		20a. Method of Disposition  1 & Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)	position (Name of penalory or other place) OF FAITH CEM. MAY 1		Location - City or To	
permit. Pages Department of Importent: If I any injury or once.		21. Signature of Funeral Service Licensee  Heather Chojnacki per DVR	22. Name and Address of Facility ASSAHN FUNERAL HON	E INC.BAL	O1 BELAIR TIMORE, MAI	ROAD RYLAND2123
/Medical Examiner spicial and parial-transit		disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. First fursion, that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	rest injurier			
death certifica e attending ph od for use as th	Physician/Medio		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ory Day Year
luiras that n signed b	by	Part tt. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	ne cause of death? ably 4 []Unknown
ian: Tha law requiras that the rtilicate has beer signed by th ctor, page 2 should be detache	Completed			24a. Was an autopsy performed'	prior to cor death?	psy findings available inpletion of cause of
ysic lis ce direc	To Be	25. Was case referred to medical examiner?  1 □ Yes 2 □ No Hospital: 1 □ Inpatient 2 ▼ EP/Outpatie	04	h (Check only one) me 5 ☐ Residence	6 ☐Other (Specify	()
Attending death. ctor: After y the fune	Certification:	27. Manner of Death  1 Natural 2 Accident  3 Suicide 4 Homicide  28a. Date of Injury (Month, Day Year)  28b. Time Injury 28b. Time (Month, Day Year)  28b. Time Injury 28b. Place of Injury 28b. Time Injury Inj	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how in OPC Company Compa	and Number of Burn	13107
Hospital 24 hours a Funerel I	Medical	29a. Certifier (Check only one)  Check only 2 Medical Examiner: On the basis of examination and/or indicated and manner stated.	ath occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the cause red at the time, date a	e(s) and manner as st and place, and due to	ated, the cause(s)
To the Hospital or within 24 hours after To the Funerel Director Completely filled in b	/Meo	29b. Signature and title of certifier	29c. License number		Date signed (Month,	
M		Pot a Poller us	OCME	Ma	4 10, 20	05
1		30 Name and address of person who completed cause or death (Item 23a) (Type 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 2 0 2005	2. Print) 111 Penn Stre		more, Mary	
St Regis	tate trar	31. Date filed (Month, Day, Year)  MAY 2 0 2005				

DHMH 17 Rev 1/2001

			1 - For State RegistramEND TTEM #1	State of Marylan  1 PER FH C843				Mental H	/giene	HARE	17033
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, Last)  A. Facility Name (If not institution, give s	le a	- 0		vn, or Location of De		eath Day		3. Time of Death
	Funeral Director		5. Social Security Number 6. Sex 416-54-5409 1XI	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Y Months Da		Irs. 8. Date of B in. (Month, D		Cou	place (State or Foreign ntry)
	be filed within 72 hours after death with the Maryland nat Hygiene. od other than "netural", or tlems 23a or 28a-f show event, the Medical Examinar must be rigitlied at	Funeral Director	MD         NA           10e. Street and Number           17 Liberty Place	Ba e Apt #3	y, Town or Lo	10f. Zip Co	21244			zen of What Cou	1.
21215-0036	'2 hours after de netural', or Items Ical Examinalm		XX Never Married Am Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 X Yes, 2 \( \) No If Yes, Give Year or Dates:	16a, Dece	1 □ Yes 2Xi	ccupation			14. Race - Americ Black, White, Specify: B]	etc. Lack
	be filed within stal Hygiene. Id other than "	Be Completed by	Elementary/Secondary (0-12)  12th grade  17. Father's Name (First, Middle, Last)	College (1-4or 5+) na		ring of work a DO NOT use re Ground	18. Mother's N	lame (First, Middle ed Easo)	e, Maiden		lanagement
re, Maryland	1 and 2 sh Health and tem 27 is m	To	Isaac Green  19a. Informant's Name/Relationship (Typ.  Shirley Green-B  20a. Method of Disposition	rooks 20b. P	238		reet and Number or monium F	Rural Route Numi	ber, City or		
Baltimore,	permit. Pages Department of I Important: If its any injury or o		1 Burial X Cremation 3 Re 4 Donation 5 Other (Specify) 21. Squature of Funeral Service License	Me	tro C	remat Name and A Narch	1			timore,	Md 21215
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or hear valure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death e cause on each line.  Due to (or as consequ	n. Do not ent	er the mode of		iac or respiratory			Approximate Interval Between Onset and Death
8760,	2129	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ							
P.O. Box 687	The law requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	ac. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregn Other (specify			2	3d. Date of delive Month	ery Day Year
	w requires that been signed I should be det	by	Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause	given in Part I.	_ 1 🗆	Yes 2	No 3□Prob	
Vital Records,		Be Completed	25. Was case referred to medical examiner?				26. Place of E	24a. Wa: auto perf 1 Yes	opsy ormed? 22 No	prior to co death?	psy findings available mpletion of cause of
of	ding Phys	은	1 Yes 2 No Ho  27. Manner of Death 1 Whatural 5 Pending 2 Accident Investigation	ospital: 1 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c.	Other: 4 Nursing Injury at Work? 1 Yes 2 No	Home 5 ☐ Res 28d. Describe			r)
Division	P Sir L	l Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	′)			City or To	wn, State)	Number or Rura	
	To the Hospital within 24 hours a To the Funeral t completely filled	Medical	29a. Certifier (Check only one) 1 Gertifying Phys 2 Medical Examin	ician: To the best of my known of the basis of examinat and manner stated.	wiedge, deatr tion and/or in	restigation, in r	ne time, date and pla my opinion, death oc cense number	ice, and due to the curred at the time	, date and	and manner as si place, and due to signed (Month,	the cause(s)
	241		30. Name and address of person who con	npleted cause of death (Item	23а) (Туре,	Print)	14397	74	hay	14, 8	broig land
	Sta Registr	. •	31. Date filed (Month, Day, Year) MAY 2 0 2005	32. Registrar's Signal	Soul	1-10	pital	Rang	4117	toan	beary land

			For State Registrar	State of M	arylan					and M	lental Hyg	giene	209.010.	
						Cei	tificate	e or L	Jeatn			Reg. No.	2005	1.7031
	Physici	an	1. Decedent's Name (First, Middle								2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic		Goldie Louise	Gauthier							May 15		005	1:00 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution,	-					Location of	of Death			County of Deat	
			Bradford Oaks N			lo on hinth days	Clin		If Under	24 Hrs	O Data of Bird	_	rince G	
	Funeral Director	tor	5. Social Security Number 579–44–5474	6. Sex 7. A 1 ☐ M 2 🔀 F	ge ( <i>in yr</i> s. i	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day	Year)	9. BIT	hplace (State or Foreign untry)
			Usual Residence of Decedent		09						Sept.	2, 1	915 Pen	nsylvania
	land land		10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	within 72 hours after death with the Maryland ene. than "natural", or itema 23a or 28a-f ehow fa M. Jical Exeminer mail the notifie of all		Maryland Prince	George's	IIr	oper Ma	arlho-	ro						1 ☐ Yes 2 X No
		Director	10e. Street and Number	000180	1 01	SPCI II	10f. Zip					10g. Citi	izen of What Co	untry?
			9109 Columbine	Court			2	0772	)			IIm	4-0-1 C-	
		Funeral	11. Marital Status	12. Was Deceden	Ever in U.	S. 13.				igin? (Sp	ecify Yes or No- Rican, etc.)		<u>ited St</u> 14. Race - Ame	rican Indian,
(0	r iter	Ē	1 Never Married 2 Marri	Armed Forces ed 1 ☐ Yes 2 ፟							Hican, etc.)		Black, White	e, etc.
<u>8</u>	al', o	þ	3XXWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	2)(24_NO	Specify:				Specify:	White
9	72 ho	ted	15. Decedent (Specify only highes	's Education		16a. Dece	kind of wor	rk dona r	durina mos	t of work	ina	16b. Ki	ind of Business/	Industry
21	l within 7; iene. r than "n	To Be Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT us	e retired	)					
21	7 2 4 2			4		Nu	rse						1th_Car	e
nd	be filed Ital Hygi od other event, I		17. Father's Name (First, Middle, I	_ast)							e (First, Middle,	Maiden	Sumame)	
<u>yla</u>			August Schneide								Singer			
Maryland 21215-0036	2 sho and is mu		19a. Informant's Name/Relationsh				_					-	r Town, State, 2	
	l and lealth		Ida M. Willett	/ Sister						-			o, MD 2	
Baltimore,			20a. Method of Disposition 1   Burial 2 □ Cremation	3 □Removal from State	206. P	lace of Dispo emetery, crei	natory or o	ne or ther plac	e)		18,	20c. Lo	cation - City or	Iown, State
Ē	Pag ment ant: ury c		`4 □ Donation 5 □ Other (Sp			thaven	Mem.	Gard	lens	20		Fred	erick,	Maryland
at	permit. Pages 'Depertment of Important: if ite any injury or of once.		21. Signature of Funeral Service	<del>ice) s</del> ee		Ré	s <b>ene</b> r	e Addre	unfer	¥1 S	ervices	, Sk	kot Cod	y P.A.
-	90 E 9 9		1/1/14			95	01 Ca	toct	in M	tn	Hwy. Fr	eder	ick, MD	21701
			23a. Paki. Enter the disease or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between											
	ากระเวลก		Immediate Cause (Final disease or condition a. Chroni histudive rumonury disease or condition resulting in death)											
	/Medical		resulting in death)	Due to (or a	s a conseq	uence of):			1		()	1000		
	Examiner		Sequentially list conditions, fary, leading to immediate cause. Enter Underlying Cause (Disease or injury											
_	D #	iner												
	and trans	Examiner	that initiated events resulting in death) Last  Due to (or as a consequence of):											
760,	death certificate be executed e ettending physicien and of for use as the burial-transit	E	Due to (or as a consequence or).											
87(	sate t	dical		d										
x 68	leath certificat ettending phy i for use as th	Me.	IF FEMALE:	23c. If yes, outcom	o of proces	nov							001.0	
Вох	ath c	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 🗌 Feta	Ideath 3	Ectopic pr						23d. Date of deli Month	Day Year
0.	at the de by the e	ysic	1 ☐ Yes 2 € No 9 ☐ Unknown	4□Pregnant : 9□ Unknown	at time or a	eam 5L	Other (sp	өспу)						
<u>Δ</u>	that the ed by detac		Part II. Other significant condition	ns contributing to death	but not res	ultina in the u	nderlvina c	ause give	en in Part I		23e. Did to	bacco u	use contribute to	the cause of death?
Records,	25 PE	Completed by					, , ,	3			1 🗆 Y	'es 2	□No 3□Pr	obably 4 <b>W</b> unknown
O	w require been sig should t										24a. Was		24h Word av	itopsy findings available
3ec	has has le 2 s										autop		prior to death?	completion of cause of
_												2 No		No
Vital	Phyaiclan: this certific ral director.	Be	25. Was case referred to medical examiner?	Hospital:				Othe	0.00		n (Check only o			
o	Phya this	J.	1 Yes 2 No 27. Manner of Death	1 Linpai		ER/Outpatier 28b. Time o		A	4 AINI	7			6 □Other (Spec	cify)
	fing After fune	lon	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury (Month, Day Year) Injury Work?						ury at 28d. Describe how injury occurred ork?  ☐ Yes 2 ☐ No					
Sign	Attending at death, ector: After by the fune	Icat	3 ☐ Suicide 6 ☐ Could i	not be	niury - At h	ome farm et					28f. Location (S	Street an	d Number or Ru	ıral Route Number,
Division	E Sign	Certification:	4 ☐ Homicide determ	building,	8e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					City or Town, State)				
	spital ours seral filled		29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only one)  Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	To the within To the	Me	29b. Signature and title of certified	71			290	. License	e number			29d. Dat	te signed (Montl	h, Day, Year)
	->-0		16/	Minne	, na.	`		1)	00-	52	999	Š	5/16	1.5
	. ^		30. Name and address of person	MUU AU who completed cause of	death (Item		Print)				/ / /	<i>/</i> :	10/70	N/ n/10
	17		ALI K	AHIMIAN		<u> </u>	501	SUX	2RA	277	ROAD	21	(10 (0)	V MD
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regis	trar's Signa	ature								
	Regist		MAY 2.0	2005 4000	1 14	for	de							

DHMH 17 Rev 1/2001

			F	State of Marylan	d / Department of I	Health and N	Mental Hyd	giene	-			
State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg. No. 2 0 0 5								17035				
	Physicia	an.	1. Decedent's Name (First, Middle, Las	)		1	2. Date of Dea Month	ath Day Yea	3. Time of Death			
	/Medic	al	KOBERT	r N,	GRIFFI	'N	MAY	17 200				
	Examin	er	4a. Facility Name (If not institution, give	MORIAL HO	12	or Location of Death		4c. County of De	) /A			
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs.	last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birti (Month, Day		Birthplace (State or Foreign Country)			
	Director		d1d-d9-1722	7 2 F 7	7 Yrs. Months Days	Hours Min.	MARCH	19,1928 1	PARYLAND			
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits			
	Mary a-f sh	tor	MARWAIN	IA	BAI	TIMOR	E CI	TY	1⊅ Yes 2 No			
	or 284	Oire	10e. Street and Number		10f. Zip Code	_		10g. Citizen of What	Country?			
	s 23a	ral	115 E. M.	ELROSE A	VENUE	2121	2	46	A			
	fter de	Funeral Director	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No	If Yes, specify Cub		Rican, etc.)	Black, Wi	merican Indian, hite, etc.			
8	72 hours after death with the Maryland "natural", or Items 23s or 28s-f show oded Examinational be notified at	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🗖 No	Specify:		Specify:	BLACK			
2-0	"natu	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of work	king	16b. Kind of Busines	ss/Industry			
12	be filed within 72 h tal Hygiene. d other than "natu	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	1	RER		TRUCKI	NO CAMPAGE			
and 2	e filed Il Hygi other vent.	Be C	17. Father's Name (First, Middle, Last)			<del></del>	e (First, Middle,	Maiden Sumame)	TO COMPAN			
		ToE	KOBERT	$\sim$ $\sim$ $\sim$	EED	ELE	ANOR	2 13,	ROWN			
Mary	12 s 7 ls rrau		19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailing Address (Street			-				
e)	s 1 and if Health Item 27 other tr	,	OTARON GKIF	FIN WAUGHTER 20b. P	lace of Disposition (Name of		Date WAY	20c. Location - City	MD. 21239 or Town, State			
ē	nt o		1. Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State   , ,	emetery, crematory or other place.		•	400004	1			
altimore,	permit. Pa Dep. rtmen Imp. rtant: any njury once.		21. Signature of Funeral Service Licens		22. Name and Addr	ass of Facility	Benwal	TR. FUNE	RAL HOME			
_	any concentration		Wietrich	N. William	NO 2140 K	1. FULTE	NAVE	BALTO.	MD 21217			
ı			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate Interval Between Onset and Death Onset and Death									
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			DRONORY	MISER	ASE	UNKNOWN			
П	Examiner			Due to (or as a conseq		ADT C	ALLUR	T	ENKNOWN			
		ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	Control and Contro	110-1	THEOR					
	and transi	Examiner	that initiated events c. CHRONIC RENAL INSUFFICIENCY						ONKNOWN			
760,	te be executed ysician and te burial-transit	ical E	Todaming in addition to the control of the control	Due to (or as a conseq	uence or):							
687	ete Po	edic		d								
Вох	eath certific attending p	Be Completed by Physician/Med	23b. was decedent pregnant	23c. If yes, outcome of pregna		v		23d. Date of o	•			
O. E	The law requires that the death certifics to has been signed by the attending proage 2 should be detached for use as the		in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of d 9□Unknown		, 		Month	Day Year			
ď	igned by be detact		Part II. Other significant conditions co	entributing to death but not res	ulting in the underlying cause gr	ven in Part I.	23e. Did to	obacco use contribute	to the cause of death?			
Records,	quires n sign uld be								2 No 3 Probably ZUnknown			
O C C	aw require s been sig 2 should b						24a. Was		autopsy findings available			
							autop perfor 1 ☐ Yes	rmed? death				
Vita	Physician: r this certifice ral director, i		25. Was case referred to medical examiner?	Hospital: 1 Angatient 2 🗆		26. Place of Dear	th (Check only or	ne)				
o	ng Pl	- To	1 ☐ Yes 2 🗷 No  27. Manner of Death	ne 5 Residence 6 Other (Specify) 28d. Describe how injury occurred								
Division of Vital		atior	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury Wo	rk? ]Yes 2□No						
N S	r Attendi er death. rector: A i by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street, factory, office		28f. Location (S City or Tow	Street and Number or a	Rural Route Number,			
	urs aff											
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Medical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as tated.									
	vithin Fo the	Me	29b. Signature and vittle of certifier		29c. Licen	se number	- 2	29d. Date signed (Mo	nth, Day, Year)			
			1 ton	1 Joen	UD ATZ	438946	-E37 1	FI, YAM	2005			
	7		30. Name and address of person who o				0.1.0-					
	, CA		PARUL AGARU 31. Date filed (Month, Day, Year)	32/Registrar's Signa	AST UNIVERSIT	1 PARKW	AY, BAL	TIMORE MAI	24 LAND 21218			
	Sta	ce ar	MAY 2 0 20		& South							

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		1 - Stete Registrer	ate of Maryland / Depa Cer	rtment of Health and Militinate of Death		ene g. No. 2005	17036	
Physic /Med		1. Decedent's Name (First, Middle, Last) ROBERT E	HEMPHILL	JR.	2. Date of Death Month	Day Year	3. Time of Death 5:30 A M	
Exami		4a. Facility Name (If not institution, give street BON SECOUNS HOS)	OITAL BALTIMORE		7883	4c. County of Death		
Funeral Director		5. Social Security Number 6. Sex  1867-9867 1244 2  Usual Residence of Decedent	7. Age (In yrs. last birthday). □ F Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthe Cour	lace (State or Foreign	
death with the Maryland ms 23a or 28a-f show rmust be notified at	tor	MD 10b. County	10c. City, Town or Loc Baltum			1	0d. Inside City Limits 1 ⊠Yes 2 □ No	
with the a or 28a be noti	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Cour	ntry?	
i i i	by Funeral	1 Never Married 2 Married 1	as Decedent Ever in U.S. 13. W med Forces? If Tyes 2 MNo	J-I 2- 2-3  Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Black		
1215- within 72 sne. than "nat	Completed	15. Decedent's Education (Specify only highest grade com	pleted) 16a. Decedo (Give k life. D	ent's Usual Occupation wind of work done during most of work O NOT use retired)	ring	6b. Kind of Business/Ind	dustry	
be file	To Be Co	17. Father's Name (First, Middle, Last) Robert E. Hem		18. Mother's Nam	e (First, Middle, Ma		gers	
C = 14 F		19a. Informant's Name/Relationship (Type, Price of Disposition)  19a. Method of Disposition	20b. Place of Dispos	g Address (Street and Number or Run  V. Paragon Street  ition (Name of atory or other place)	t Back			
Baltimore, permit. Pages 1 at Department of Hea Important: If itam any injury or otha		1 Surial 2 Cremation 3 Remov 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Mary lav	Name and Address of Facility Ronald A Grays OF W. Muth				
Pnysician	02 1	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final disease or condition	s that caused the death. Do not ente				Approximate Interval Between Obset and Death	
death certificate be executed was eattending physician and dior use as the burial-transit	dical Examiner	Sequentially list conditions, 1 any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  c.	Due to (or as a consequence of):  LWWG CAWCE  Due to (or as a consequence of):	ER, TERMIN	AL.		MONTHS	
P.O. Box 68 that the death certificated by the attending plateached for use as a	Physiclan/Med	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year	
cords, P.O w requires that the been signed by th should be detache	by	Part II. Other significant conditions contribut	ng to death but not resulting in the und	derlying cause given in Part I.		cco use contribute to th	. 1	
Rec The law ate has b	Completed				24a. Was an autopsy performe	prior to con death?	osy findings available inpletion of cause of	
Division of Vital F or Attanding Physician: The after death. Director: After this certificate in by the funeral director, page	atlon: To Be	1 1 1 es 20 110	26. Place of Death Check onlone    Comparison					
Division of To the Hospital or Attanding F within 24 hours after death.  To the Funaral Director: After completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined 286	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Loca City			tion (Street and Number or Rural Route Number, or Town, State)		
he Hospital n 24 hours a ha Funaral I	Medical	(Check only 2 Medical Examiner: 0	To the best of my knowledge, death in the basis of examination and/or invend manner stated.	occurred at the time, date and place, estigation, in my opinion, death occurr	and due to the cau red at the time, date	se(s) and manner as state and place, and due to	ated. the cause(s)	
^	W	29b. Signature and title of certifier    JMT V - Mof	weels, mos	29c. License number	2	1. Date signed (Month, I	_	
,7		30. Name and address of person who complete  JANET V - MOG HATEL  31. Date filed (Month Day Year)	ed cause of death (Item 23a) (Type, P 1, MD Hown U	rint) )-BAITIMANE STRE	et, Asheari	nont, MD:	21223	
Sta Regist	100	31. Date filed (Month, Day, Year) MAY 2 0 2005	32. Registrar's Signature	9				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Ragistrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 5<sup>Month</sup>18 HURT DEMIES NORMAN 2005 **Physician** 10:45a.<sup>M</sup> /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Manor Care-Rossville Rosedale Baltimore Timedeath. May 18,2005 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, 10 8 Birthplace (State or Foreign Country)
 VA 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1922 **Funeral** 1**√x**M 2□ F Yrs Director 224-22-2392 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show 1X Yes 2 □ No MD N/A Baltimore Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 1273 Kitmore Road 21239 239 Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yas 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: by 3 Widowed 4 Divorced "naturel" Completed if Health and Mental Hygiene.
item 27 is marked other then "natur
other traumetic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 6th N/A Security Baltimore Gas & Elec. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) X16:10/08/1923 12 should be fill and Mental H Be Jessie Hurt LeVirt Wood 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 ls any injury or other trai <u>once.</u> Gloria Worthan-daughter 1273 Kitmore Road Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State ` 4 ☐Donation 5 ☐ Other (Specify) Garrison Forest VA 5/26/2005 Owings Mills 22. Name and Address of Facility MARCH FUNERAL HOME—EAST 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1101 E. North Avenue Baltimore, MD 21202 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPOXIA Pnysician DAYC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 46065 Due to (or as a consequence of): Examiner CONGESTIVE Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ ARTERY 1 Yes 2 Ner 3 Probably 4 Unknown DISSINE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2/ No 1 ☐ Yes Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No ို this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: Injury Attending 1 Natural 5 Pending investigation Division 1 ☐ Yes 2 ☐ No after death.

I Director: Af
d in by the ful 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide ō 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person wife completed cause of death (Item 23a) (Type, Print) BALLO. Suite 200 9106 PHILIDAPINA DENNIS . # SDIE 31. Date filed (Month, Day, Year) MAY 2 0 2005 327 Registrar's Signature State Registrar

R.	J-03364 J		1 - For State Registrar	State of Mai		ertificate of		and Mental Hy	rgiene Reg. No. 200	5 17038
	Physicia		1. Decedent's Name (First, Middle, La April Marie	*				Date of D     Month     May 16	Day Y	3. Time of Death  0:05 a. M
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	r Location		4c. County of	
			500 North Montfor	d Avenue		Baltimo			N/	
	Funeral		5. Social Security Number 6. S 2 1 3 - 8 8 - 2 7 2 9		(In yrs. last birthda) 9 Yrs.	Months Days	If Under Hours	Min. (Month, D	ay, Year)	Birthplace (State or Foreign Country)
	Director	}	Usual Residence of Decedent	A 2	9 113.			April	12,1976	Maryland
	yland yland		10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	Be-1 sl	ctor	Maryland Harfo	rd		allston				1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number	,		10f. Zip Code			10g. Citizen of Wh	at Country?
	sath v	eral	2037 Durham Roa	12. Was Decedent Ev	ver in IIS 13		1047	igin? (Specify Yes or N	U.S.A.	American Indian,
<b>'</b> 0	fter d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕱 No	)			igin? (Specify Yes or N n, Puerto Rican, etc.)	Black,	White, etc.
9	72 hours after death with the Maryland Inatural; or Items 23e or 28e-f show Iteal Exactions to notified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify:	White
5-0	72 ho	Completed by Funeral	15. Decedent's E (Specify only highest gra		(Giv	edent's Usual Occup e kind of work done DO NOT use retire	during mos	at of working	16b. Kind of Busin	•
7	within ene. than	duc	Elementary/Secondary (0-12) 12th Grade	Coilege (1-4or 5+	) I	aborer	0)		General Constru	
р 5	filed Hygie other ent.	o C	17. Father's Name (First, Middle, Last	)			18. Moth	er's Name (First, Middle		Caon
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or items 23e or 28e-1 show any injury or other treumatic event, II's Marical Examinet mast be notified at anone.	To Be	Kenneth Marti						hultz	
Mar	12 sh h and 7 is m treum		19a. Informant's Name/Relationship ( Mrs. Mary Jo Gaf					er or Rural Route Numl Fallston,		ate, Zip Code)
e,	s 1 and 2 of Health a item 27 is other treu		20a. Method of Disposition	y (morner	20b. Place of Disa	osition (Name of		Date Date	20c. Location - Ci	ty or Town, State
I OIL	Pages ent of nt: If i		1 ☐ Burial 2 X Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Special		1	ematory or other pla Crematori		5/21/2005	Baltimor	e, Maryland
Baltimore,	Departm Departm Importer any inju		21. Signature of Funeral Service Lice			22. Name and Addre	ss of Facili	iy Schimunek	Funeral	
8	88 = 8		> Stefanic	"PUN	eren	9705 Beld	ur Ro	d., Baltimo	re, MD 2	1236
8760,	Physician /Medical Examiner but street percent street but street b	ai Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. SXANGUI Due to (or as a b. INGUINAL Due to (or as a	Consequence of):  FISTICA  consequence of):		TT NG-	WITH INGUIT		Approximate Interval Between Onset and Death
O. Box 6	death certific e attending p id for use as i	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	23c. If yes, outcome o 1  Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of Month	
Δ.	requires that the een signed by th nould be detache	by PI	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause giv	ven in Part I			ute to the cause of death?
prd	w require been si should I							1 🗆	Yes 2. ZNo 3	☐ Probably 4 ☐Unknown
Vital Records,	has b	Completed						24a. Wa auto peri 1 134 Yes	opsy prio ormed? dea	re autopsy findings available of to completion of cause of th?
ital	ysicien: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?	2			26. Place	e of Death (Check only		
of V	Physicien: this certific ral director.	၉	1 XYes 2 No	Hospital: 1 Inpatien			4 🔯 🕅	ursing Home 5 Res		(Specify) At scene
OU C	ding F h. After funera	ion	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	Wo	ryat rk? ]Yes 2. □		how injury occurred	
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	e 28e. Place of Injur	y - At home, farm,	treet, factory, office		28f. Location	(Street and Number own, State)	or Rural Route Number,
ā	rs after el Dire	Cert	4   Homicide	building, etc.	(Specily)			City of Te	wii, State)	
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical		nysician: To the best of miner: On the basis of e and manner state	examination and/or					
	To the vithin 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed (	
•			P unesk						May 16,	
	1		30. Name and address of person who	completed cause of de-	ath (Item 23a) (Typ	<sup>9, P</sup> 1111 Penr	Stre	eet Baltimo	re, Maryla	and 21201
	Sta Registi		31. Date filed (Worth, Pay, Year) WAY 2 0 200		's Signature	NE)			<del>-, , , , , , , , , , , , , , , , , , , </del>	

State of Maryland / Department of Health and Mental Hygiene

State Registracemend item #18 per fh g843 5 Postificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** :45 PM 2005 F. Hewitt Sara /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Franklin Woods Nursing Center Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day. Year) | 916 9. Birthplace (State or Foreign Country) New YORK 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 ☐ M 2 🖫 F 89 121-10-2311 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County in than "insturel", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 👿 No Director Baltimore White Marsh Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21162 U.S.A. 5616 Harvey Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 δ 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore County aith and Mental Hygiene. 27 is marked other than ir traumatic event, it o Me Elementary/Secondary (0-12) College (1-4or 5+) 5+ Reading Specialist Public Schools 18 CARMELAN (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe sry injury or other traumatic event, 0069. 17. Father's Name (First, Middle, Last) Be Carmella Gambacorta Cataldo Ferraro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5616 Harvey Court, White Marsh, MD Mrs. CarolAnn Baglin (dghtr) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 5/19/2005 Timonium, Maryland Dulaney Valley Mem'l | \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Gangrene Physician /Medical Tue to (or se a consequence of): ascular Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day detached for 5 Other (specify) 4 Pregnant at time of death Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ed bluods 3 ☐ Probably 4 ☐ Unknown 2 X No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 2 No 1 Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 XYes 2 No director Be 26. Place of Death (Check only one, Other: Hospital: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl To the Funeral Director: completely filled in by the 6 Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) anklin 3. Registrar's Signature State Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1:33 PM **Physician** Gloria Cornelia Haas 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore ranklin Sa Kosedale If Under 1 Year | If Under 24 Hrs. uare whital Birthplace (State or Foreign Country)
 ILLUNOUS 8. Date of Birth (Month, Day, May 3, 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Days 1 ☐ M 2 ☐ YF 217-28-9358 74 Director Usual Residence of Decedent 10d. Inside City Limits should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f show Itam 27 is markad othar than "natural", or Itams 23a or 28a-1 show othar traumatic evant, the Modical Examinational over contilled at 1 ☐ Yes 2 No Directo |Maryland | Baltimore Perry Hall 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 9600 B Haven Farm Road 21128 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) i and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hospital Computer Programmer 12th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wallace. Madeline Atkinson Norris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2: Department of Health at Important: If Itam 27 is any injury or othar trau <u>once.</u> 10467 Petersboro Rd., Woodstock, MD Mrs. Deborah Miller (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5/23/2005 Baltimore, Maryland Bayview Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hemorrhag Pnysician ntracranial /Medical Due to (or as a consequence of): **Examiner** Blood Due Ku(or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 No 1 Yes To tha Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death, To the Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar OF-rowklin

quare Dr.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAY 2 0 2005

Certificate of Death

Dhusisi		1. Decedent's Name	e (First, Middle,	Last)								2. Date of De Month	Da		Year	3. Time of	Death,
Physici /Medio		Evely	n			Hi11						May 8,				2:25	AM M
Examir	er	4a. Facility Name (II								r Location			_	_	of Deeth		
			Care Nur	SING CE		(In yrs. la	last hirtho			er Sp		8. Date of Bir	th	i	gome	plece (Stete or	Foreign
Funeral Director		5. Social Security N 214-74-1		1 □ M 2 😾 F		60	Yrs	Months		Hours	Min.	May 12	y, Year	344	Cou	ginia	orbigit
		Usuet Residence of	Decedent														
ylan how		10a. State	10b. County					r Location								10d. Inside Cit	
e Ma	cto	MD				Ва	altin	nore								1 🔀 Yes	2 U NO
ith th	Director	10e. Street and Nur		A				10f. Zip	Code 212	20		:	_		What Cou	intry?	
ath w	ral	571 Beac	nriela			'- 11	0	10.11/-			i=i=2 /C=		US		o Amor	ican Indian,	
er de Itami	Funeral	11. Marital Status 1 ☐ Never Marri	ind 2 Marris		Forces?		5.	If Yes, spe	city Cuba	an, Mexica	n, Puerto	ecify Yes or No Rican, etc.)	-		ck, White		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avant, the Macdisal Examinal moral be notified at once.	ρ	3 Widowed	4 Divorced	Year	Give X Give X r Dates:			1 🗆 Yes		Specify	:			Specify		Black	
natu	ete	(Spec	15. Decedent's cify only highest	Education grade complete	d)		16a. De	ecedent's Usua Give kind of wo fe. DO NOT u	al Occup rk done se retirer	ation during mos d)	st of work	ing	16b. F	Kind of B	usiness/l	ndustry	
withir ene. then	Completed	Elementary/Seco	ondary (0-12)	Colleg	e (1-4or 5	+)		urse's					H	lea1t	h Ca	ire	
filled Hygi other	a)	17. Father's Name	(First, Middle, L	ast)		-				18. Moth	er's Nami	e (First, Middle	, Maidei	n Suman	10)		
lental lental rkad tic av	0 8	Ruben Sn	nith								Patty	y Eldri	dge				
should Name	-	19a. Informant's Na	ame/Relationsh	p (Type, Print)			19b. M	lailing Address	(Street	and Numb	er or Run	al Route Numb	er, City	or Town,	State, Z	p Code)	
and 2 alth a		Walter H	Hill - S	Son						eld A		Balti	more	, MI	21	229	
of He of He fitem		20a. Method of Disp	position  Gremation	3 □Removat fr	om State	20b. P	tace of D emetery,	isposition (Nat crematory or c	ne of other plac	ce)	I	Date	20c. L	ocation -	City or T	own, State	
Pag ment ant: h		` 4 □ Donation			oni otato	Me	trop	olitan	Cre	nator	y 5-	-8-05	A	lexa	indri	la, VA	
eparti eparti nport ny inj DCB.		21. Signature of Fu	nerat Service L	icensee	10		$\bigcirc$	Bland	d Addre	ss of Eacil	nera.	l Home					
907 e a		23a, Part1, Enter t				the death	Do 200					Farmvi		, VA	239	Approximate	
		shock, or hea	irt failure. List o	nly one cause of	n each lir	e.	1. 100 1101	n				Α.				Interval Bety	veen
Physician /Medical		disease or condition	(Final	a	(	an	ari		nen	ng	teer	lune			İ	lmm	edill
Examiner			Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Concertive Weart Facture  1 43										1				
<del> </del>	ē	Sequentially list co	nmediate	b. ——Due	to (or as	a consequ	uence of)		10	600	Tu	i cur q	-		1	,	
uted d ansit	Examiner	cause. Enter Under Cause (Disease or that initiated events	injury			H	900	rton	Mo	N						5 10	1
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ath certificate be executed trending physician and or use as the burial-transit	an/Medical			d		2	Im	al	ste	nos	11					1017	7
e as t	Med	IF FEMALE:		00- 11-10-		-4											
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at the de by the	Physic	1 ☐ Yes 2 ☐ 9 ☐ Unknown			nknown	time or de	oaui	3 🗆 Ottibi (a)	<i>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</i>								
that the	y P	Part II. Other signi	ficant condition	ns contributing t	o death b	ut not resi	ulting in th	ne underlying (	ause giv	en in Part	I.	23e. Did	tobacco	use con	tribute to	the cause of de	eath?
w requires that been signed to should be deta	ed by											1 🗆	Yes 2	2 □ No	3 ☐ Pro	bably 4 🗇	nknown
s bee	Completed											24a. Was	an	24b.	Were au	opsy findings a	vailable
The law cate has page 2	шо												psy ormed? 2 ⊡ N		death?	2□ No	.058 01
sician: certifica rector, p	BeC	25. Was case refer	rred to medicat							26. Plac	e of Deat	h (Check only					
hysic his ce I direc	10	examiner?	No.	Hospital:	☐ Inpatie	nt 2 🗆	ER/Outp			4 🗀 N	ursing Ho	me 5 Res				ify)	
ding Ph h. After th funeral		27. Manner of Dea 1 ☑Naturat	th 5 Pending	/1	ate of Inju Month, Da	ry y Year)	28b. Tin Inju		28c. Injui Woi			28d. Describe	how inju	ury occur	red		
tendi leath. tor: A the fu	cati	2 Accident	investig 6 ☐ Could n	ot be		44.5	(	М		Yes 2	JNO	Opt Leasting	Ctroot	and Alumi	or or Pu	ral Route Numi	har
or At after of Direction by	Certification:	4  Homicide	determi	nod 208. F	uilding, et	c. (Specif)	y)	i, street, factor	у, опісв			City or To			)BI 01 114	ar riobie rebini	701,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Ce	29a. Certifier (Check only	1 Certifying	Physicien: To Examiner: On the	e basis of	f examina	wiedge, o	death occurred	at the ti	me, date a	nd place, ath occur	and due to the	cause(	s) and mand place,	anner as and due	stated. to the cause(s)	
the	Med	one) 29b. Signature and	title of certifier	and r	nanner sta	ated.		29	c. Licens	se number			29d. D	ate signe	d (Month	, Dey, Year)	
T W S		250. Signaturo and		1	M	$\sim$			1	09	2.5	1	~	-15	3/1	Y	
6		30. Name and add	ress of person	vno sempleted	ause of d	eath (Item	n 23a) (Tr	vpe, Print)	V -	- 3 [	~ 5	1	7	. ] 2	, ,		
			SITIAE	A-Mp	LIK	m()	Po	Box 6	36	13	unt	onser	11/0	, 1	10	208	166
	ate	31. Date fited (Mo	MAYY ZOWY	2005	. Registr	ar's Signa	ture	Card :									
Regist	rar			1	A JAR	1 19	15	1542									

			State of Maryland / Department of Hea	ulth and Mental Hygiene	
		_	1-State Registranment item #5 per fh g843 5/2097 tilicate of De	eath Reg. No.)	1-701.0
	Physicia /Medic	an al	Georgia Henson	May 17, 2005	4:35 M
	Examin	er	4a. Facility Name (Kolot institution, give street and number)  4b. City, Town, or Loc  4b. City, Town, or Loc  Baltin	cation of Death  4c. County of Death	
	Funeral Director	ķ	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If		lace (State or Foreign try) A Carolina
	Maryland f show		10a. State 10b. County 10c. City, Town or Location	11	0d. Inside City Limits 1 No
	death with the Maryland ime 23a or 28e-f show r nust be notified at	Direct	10e. Street and Number  10f. Zip Code	10g. Citizen of What Coun	itry?
"		Funeral Director	1 Never Married 2 Married 1 Yes 2 No	inic Origin? (Specify Yes or No- dexican, Puerto Rican, etc.)  14. Race - America Black, White,	
003	hours after turel', or Ite	by	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation	Specify: Specify: B	lcK tustry
21215-0036	within 72 ene. than "nal	Completed	(Specific only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	ig most of working  Local Domes	tic
	be filed within tal Hygiene. d other than 'event, the Ms	Be Co		. Mother's Name (First, Middle, Maiden Surmarne)	
Maryland	should and Men le marke	인	19a. Informant's Name/Relationship (Type, Print) COUSIN 19b. Mailing Address (Street and	Lena Kicharasci Number or Rural Route Number, City or Town, State, Zip	Code)
	1 and 2 s Health ar em 27 le ther treu		Mrs. Agnes Richardson 3712 Cran 20a Method of Disposition 20b. Place of Disposition (Name of	Stop Ave. Baltamo	1,21229
Baltimore,	Page nent c snt: If ury or		1 ★ Burial 2 □ Cremation 3 □ Removal from State  1 ★ Burial 2 □ Cremation 3 □ Removal from State  1 ★ Burial 2 □ Cremation 3 □ Removal from State  1 ★ Burial 2 □ Cremation 3 □ Removal from State  1 ★ Burial 2 □ Cremation 3 □ Removal from State  1 ★ Burial 2 □ Cremation 3 □ Removal from State  1 ★ Burial 2 □ Cremation 3 □ Removal from State  1 ★ Burial 2 □ Cremation 3 □ Removal from State  1 ★ Burial 2 □ Cremation 3 □ Removal from State  1 ★ Burial 2 □ Cremation 3 □ Removal from State  1 ★ Burial 2 □ Cremation 3 □ Removal from State  1 ★ Burial 2 □ Cremation 3 □ Removal from State  1 ★ Burial 2 □ Cremation 3 □ Removal from State  1 ★ Burial 2 □ Cremation 3 □ Removal from State  1 ★ Burial 2 □ Cremation 3 □ Removal from State  1 ★ Burial 2 □ Cremation 3 □ Removal from State  1 ★ Burial 2 □ Cremation 3 □ Removal from State  1 ★ Burial 2 □ Cremation 5 □ Other (Specify)	15/25/2005 Balto, 1	Md.
Balt	permit. Page Department of Importent: If any injury or once.		21. Sig ature of Funeral Service/Licensee 22. Name and Address of OSEPh 222.2 W. No.	Euss Funeral Home, P.	A.
			23a. Part   Enter the disease, or complications that caused the death. Do not enter the mode of dying, so shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)  a.   ATUE ROSCLE ROTIC CAR  Due to (or as a consequence of):	- DIOVASCULAN DISFASE	YEARS
		lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
760,	sician and burial-transit	I Examin	resulting in death) Last  C  Due to (or as a consequence of):		
6876	<u> </u>	edical	d		
Box	The law requires that the death certificate the bas been signed by the attending phy agge 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	23d. Date of deliver	ory Day Year
s, P.O	es that the de igned by the a be detached t	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in		
Records,	w require been sig	leted	CEREBROVASCULAR ACCIDENT	1 ☐ Yes 2 ☐ No 3 ☐ Prob	psy findings available
II Re		Completed	MULTIPLE DECUBITI	autopsy prior to coll performed? prior to coll death?	mpletion of cause of
Vital	ician: certific	o Be	avaminar?	6. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specifi	iv)
of	ng Their	H-	27. Manner of Death 28a. Date of Injury 28b. Time of Injury at 15 Pending (Month, Day Year) Injury Work?		,,
Division	l or Attendate after death	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rura City or Town, State)	al Route Number,
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, one on the basis of examination and/or investigation, in my opinic and manner stated.		
	To th within To th	Me	29b. Signature and the of certifier  29c. License nu	umber 29d. Date signed (Month,	Day, Year) Th. 2005
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Man Port # 100 ANI	)2/220
		ate	29b. Signature-and the of certifier  As anthar (cum as in Digitary)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  M VASANTHA KUMAN MD - 516 N RO  31. Date filed (Month, Day, Year)  MAY 2 0 2005	ming wall, 4 108, 1010	
	Regist	rar	MAIR U LUUJ JUJULA JA		

			- FOI	partment of Health and Nertificate of Death		2000 17010
			Registrar  1. Decedent's Name (First, Middle, Last)	erinicale of Death	Reg. N	
	Physicia		Helen Frances Howe		Month 18	2005 4:05 AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
			5. Social Security Number 6. Sex 7. Age In yrs. last birtho	TUnder 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Funeral Director		215-28-6261 1 M 2 N F 73 Yrs	Months Days Hours Min.	(Month, Day, Yea,	931 Country) Virginia
	pu *		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town of the county	r Location		10d. Inside City Limits
	Marylan f ehow	ō	MD Anne Arundel Pasader			1 ☐ Yes 2 📉 No
	r 28a-	irect	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
	23e o	al D	236 10th Street	21122		USA
(0	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other than "naturel; or Items 23e or 28e-f ehow or other treumatic event, the Medical Exam are must be notified at	Funeral Director	1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 🕅 No	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	urel', c	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	405	Specify: White
15-	in 72 h	Completed	(Specify only highest grade completed) (C	ecedent's Usual Occupation Give kind of work done during most of work fe. DO NOT use retired)	king 16D.	Kind of Business/Industry
212	giene.	Com	Elementary/Secondary (0-12) College (1-4or 5+)  9	lomemaker		Own Home
pu	be filed stal Hygi d other	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maide	·
Maryland	2 should be filed withir and Mental Hygiene. is markad other then eumatic event, Ite M.	7	Forest A. Carter  19a. Informant's Name/Relationship (Type, Print)  19b. Name/Relationship (Type, Print)	LUCY JU  Nailing Address (Street and Number or Rui	ne Warlitn ral Route Number, City	
Ma	nd 2 salth an 27 is rreu		, , , ,	Alan Drive, Apt. H		
ore,	es 1 a of Hea of Item r othe			crematory or other place)		Location - City or Town, State
Baltimore,	Pag tment tent: I jury o		'4 □Donation 5 □ Other (Specify)		3/2005 E	lkridge, MD
Ball	permit. Pages 1 and 2 s Department of Health ar Importent: If Item 27 is any injury or other treu QRE.		21. Signature of Furnital Arvice Licensee	22. Name and Address of Facility  Gary L. Kaufman Fun  7250 Washington Bly	eral Home@	Meadowridge MP, Inc. ge, MD 21075
			23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest.	Approximate Interval Between Onset and Death
	Physician /Medical		resulting in death)	Head and Neck	Cancer	
	Examiner		Due to (or as a consequence of)	:		
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	8		
	ate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last			
8760,	cate be execut physician and the burial-tran	dical E	3	•		
9	tificate ig phys as the	ledic	0.		-	
Вох	death certific e attending p ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?    23c.   If yes, outcome of pregnancy	3 Ectopic pregnancy	- 1	23d. Date of delivery  Month Day Year
	0 0 0	ysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death	5 Other (specify)		
Д	requires that the leen signed by th hould be detache	by Ph	Part II. Other significant conditions contributing to death but not resulting in t	ne underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ord	w require been sig should b	ted t			1 Tes	2 No 3 Probably 4 Unknown
Division of Vital Records,	e law has b	Completed			24a. Was an autopsy performed)	24b. Were autopsy findings available prior to completion of cause of death?
tal	ician: The certificate ha	e Co	25. Was case referred to medical	26. Place of Dea	th (Check only one)	No 1 ☐ Yes 2 M No
fVi	Physician: this certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	Other -		6 ☐Other (Specify)
0 0	fe lug		27. Manner of Death 28a. Date of Injury (Month, Day Year)  28b. Tir	ıry Work?	28d. Describe how in	jury occurred
isio	Attending or death. sctor: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fam		28f. Location (Street	and Number or Rural Route Number,
Div	el or / s after of Dire	Certi	4 Homicide determined building, etc. (Specify)		City or Town, Sta	are)
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medicel Examiner: On the basis of examination and/and manner stated.	death occurred at the time, date and place or investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	ro the vithin 2 of the comple	Med	29h Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	-> PO		Deorge C. With II 17.	•		y LP, 2005
	8		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print) tal Drive (s	len Burn	ie MD, 21061
	U Ct	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature			J
A.	Regist		MAY 2 0 2005	Least 8		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2005 Augustá M. Hayden May 12 12:15PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Villa Nursing Home Catonsville Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct. 12, 1907 If Under 1 Year 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthdav) 5. Social Security Number 6. Sex **Funeral** Months Days 1 M 2 XF 97 Director 216-14-8925 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marcal Exercises. 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Ellicott City MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3004 North Ridge Road 21043 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hairdresser Beauty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Margaret Meredith William Zeltman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Apt. PV514 19a. Informant's Name/Relationship (Type, Print) 715 Maiden Choice Lane Margaret Smith Niece Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State □ Burial 2 □ Cremation 3 ☑ Removal from State Forest Lawn Cemetery 5-17-2005 Richmond, VA 4 ☐ Donation 5 ☐ Other (Specify) Signature Funeral Service Lice 22. Name and Address of Facility Ambrose Funeral Home, 1328 Sulphur Spring Road, Arbutus, MD 21227 ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the buria Division of Vital Records, P.O. Box 68760, by Physiclan/Medical Due to (or as a consequence of) attending p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the causa of death? 4☐ Unknown 1 ☐ Yas 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 2000 Other: 1 ☐ Yes Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 □ No after death Director: A d in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D completely filled filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death Jiem 23a) (Type, Print) Frederick Nd Al 162 NAMOSE RODOL 31. Date filed (Month, Day, Year) MAY 2 0 2005 Registrar

			Please T	ype or Prir	nt in Black In	delible Ink. Ensi	ure All Copies	Are Legible.	
			For State	State of Ma		artment of Health		iene	
			Registrar     Decedent's Name (First, Middle, Last)		Cei	tificate of Death	2. Date of Deat	eg. No:	3. Time of Death
	Physici /Medio		LINTON PRET	WOUT	HICKS	3	MAY	Day Year	0241 M
	Examir		4a. Facility Name (If not institution, give s		F3 . 1 . 20	4b. City, Town, or Location	^	4c. County of Death	h
	Funeral		5. Social Security Number 6. Sex	7. Ag	MORE (In yrs. last birthday)		r 24 Hrs. 8. Date of Birth	9. Birth	hplace (State or Foreign
	Director		001F-FC-F1X	M 2□F	56 Yrs.	Months Days Hours	Min. (Month, Pay,	49 VIR	GINIA
	yland		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation			10d. Inside City Limits
	8e-f s	Director	MD		BALTI	MORE			1 Yes 2 No
	a or 2	Dire	10e. Street and Number	ZEDON	DUE	10f. Zip Code	1	0g. Citizen of What Co	Untry?
	ems 2:	Funerai	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13.	Was Decedent of Hispanic Or f Yes, specify Cuban, Mexica	rigin? (Specify Yes or No-	14. Race - Amer Black, White	
36	rs after	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 10 N If Yes, Give Year or Dates:	No	1 ☐ Yes 2 M No Specify		Specify: 3	LACK
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is merked other then "naturel", or Items 23a or 28e-f show or other treumatic event, the Medical Examinatmental terminish at	eted	15. Decedent's Edu (Specify only highest grade	ation	16a. Dece	dent's Usual Occupation kind of work done during mos	et of working	16b. Kind of Business/i	industry
2	filed within Hygiene. ther then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retired)	10	MULLIC	00
1d 21	if Hygin other	Be Co	17. Father's Name (First, Middle, Last)		IRU	18. Moth	er's Name (First, Middle, M	faiden Surname)	100.
Maryland	2 should be and Mental Is marked o	ToE	MASON HI	CKS		AUG	BERTA P	ARKER	
Mar	id 2 sh lih and 27 Is m treum		19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Mailir	g Address (Street and Numb	er or Rural Route Number,	City or Town, State, Z	ip Code)
ore,	of Health of Health fitem 27 r other tr		20a. Method of Disposition	10000	20b. Place of Dispo	sition (Name of natory or other place)	Date	20c. Location - City or 1	Town, State
Baltimore,	Pa ant ury		1 ☐ Burial 2 ☐ Cremation 3 ☐ R  '4 Donation 5 ☐ Other (Specify)		ANATOM	Y GIFTS REG	5/11/05	<b>HANOVE</b>	R,MD
Ba	permit. Departrimportri		21. Signature of Edneyal Service Libense	int	22	Daugherty Family Fu	neral Home And Crema	ition Center, P.A.	
	F80.97		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	e cause on each lir	eath. Do not ent	2601 Mountain er the mode of dying, such as	Road - Pasadena, M cardiac or respiratory arre	D. 21122 est,	Approximate Interval Between
	Physician	(S) 2	Immediate Cause (Final disease or condition resulting in death)	Aw		REATITIS			Onset and Death 5 DAYS
	/Medical Examiner			Due to (or as	a consequence of):				
Ţ	D = 0	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of):				
V	xecuted and I-transit	xamin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):				
68760,	The law requires that the death certificate be ex the has been signed by the attending physician page 2 should be detached for use as the burial	caiE		500 10 (01 00 1	a consequence ory.				
	ortificate ing physi a as the b	Medicai	IF FEMALE:						
Вох	feath certifica attending ph for use as t	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deliving Month	very Day Year
Ö.	tt the de by the tached	Physician/M	1	9□ Unknown	time of death 3	Cural (specify)			
s, P	res thai igned b	by	Part II. Other significant conditions con					acco use contribute to	M
Records,	w requir been si should	Completed	HEPATITIC C, HO					s 2 No 3 Pro	
Rec	The lav	omp	~ '	MELLIT	rus, Hype	ZTENSION,	24a. Was ar autopsy perform	y prior to co ned? death?	opsy findings available ompletion of cause of
Vital		Be C	25. Was case referred to medical examiner?			26. Place	1 ☐ Yes 2 e of Death <i>Check on one</i>	No 1 □ Yes	2 <b>/25</b> ,No
of V	this aldir	2	1 ☐ Yes 2 No H	ospital: 1 Inpatie		Other: 4 Nu	ursing Home 5 Reside		ify)
ion	nding I ath. r: After e funer	Certification:	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐	28d. Describe ho	w injury occurred	
Division	or Attendiater death.  Director: A Jin by the fu	rtifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	ury - At home, farm, stre c. (Specify)	eet, factory, office	28f. Location (Str. City or Town,	eet and Number or Rur , State)	ral Route Number,
	spitel or At ours after o nerel Direct filled in by		29a. Certifier Tertifying Phys	ician: To the hest	of my knowledge door	occurred at the time, date an	ad place, and due to the	uso(a) and =====	otated
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical	(Check only one)	er: On the basis of and manner sta	examination and/or inv	restigation, in my opinion, dea	ath occurred at the time, da	te and place, and due t	to the cause(s)
	To t To tl	Σ	29b. Signature and title of certifier	) un	VI.00	29c. License number	4	d. Date signed (Month,	, Day, Year)

State Registrar

1. Date filed (Month, Day, Year)

1. Date filed (Month, Day, Year)

1. A 1 2 0 2005

SINAI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSPITAL OF BALTIMORE

			1 - For State Registrar	State of N	/larylar		artmen rtificat				1ental H	ygien Reg. N	20	115	1701.6
			Decedent's Name (First, Middle, Las	it)							2. Date of	Death		<u> </u>	3. Time of Death
	Physici /Medio		Margaret Ir	<i>1</i> a	Hu11						May 1	7, 2	005	Year	7:00 P <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give	street and number	r)				Location	of Death		4	c. County	of Death	
			Mariner Health				Gle	n Bu	rnie			A	nne .	Arund	le1
	Funeral		5. Social Security Number 6. Se	9X 7. A □ M 2 □ F		last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of I	Birth Qay, Yea	£	9. Birthp	lace (State or Foreign
H.	Director		213 03 1730	- M 287	89	Yrs.					Feb 1	0, 1	916		land
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							1	Od. Inside City Limits
	Aaryl f eho	ō	MD Anne A	w		•									1 ☐ Yes 2 TrNo
	the the 28a-	Director	10e. Street and Number	runder	G.	len Bu	10f. Zip	Code				10a C	Citizen of V	What Cour	itry?
	With Ba or	<u></u>	7900 Benesch Cir	cle				1060					USA	711at 000	,
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f ehow than Madical Examiner must be notified at	Funeral	11. Marital Status	12. Was Deceder		I.S. 13.	Was Deced	dent of Hi	spanic Ori	gin? (Sp	ecify Yes or I			e - Americ	an Indian.
(0	r Iter	F	1 Never Married 2 Married	Armed Forces			If Yes, spec	offy Cubar	n, Mexicar	i, Puèrto	Rican, etc.)			k, White,	
8	al', o	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	:		1 ☐ Yes	2 XI No	Specify:				Specify	: Wh	ite
9	72 ho	Completed	15. Decedent's Ed (Specify only highest grad	ucation	_	16a. Dece	dent's Usua kind of wor	al Occupa	tion	t of work	ina	16b.	Kind of Bu	siness/In	dustry
7	ithin	nple	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	DO NOT us	se retired,	)	O WOIN	y				
7	ygien ygien t, th	Co	8th			I	Homema	aker					wn Ho		
<u>n</u>	tal H d oth	Be	17. Father's Name (First, Middle, Last)	T							(First, Mida			10)	
<u>Ş</u>	Men Marke Marke	ဥ	Charles H. Furst								t R. S				
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan II of Health and Menth Hygiene.  If filem 27 is marked other than "natural", or liems 23a or 28a-f show if it item 27 is marked other than "natural", or liems mail be notified at or other traumatic event. The Madical Examiner must be notified at	1 18	19a. Informant's Name/Relationship (7	ype, Print)		19b. Maili	ng Address	(Street a	nd Numbe	er or Aura	al Route Num	nber, City	or Town,	State, Zip	Code)
dî dî	Health Health tem 27 other tra		Bonnie Edwards		205 5		iichel		r.		ersvil				
0	ges 1 t of F If ite or ot		20a. Method of Disposition  12 Burial 2 Cremation 3	Removal from State	e (	Place of Disponentery, crea	matory or o	ther place			Date		Location -	•	wn, State
٥	tant:	١,	`4 ☐ Donation 5 ☐ Other (Specify		Lot	idon Pa							1timo		
Baltimore,	permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other 2005.		21. Signature of Funeral Service Licen	500							udon P				
	ans a d		23a. Part 1. Enter the disease, or comp	es							Baltim		MD Z	21229	Approximate
	Physician /Medical Examiner	al Examiner	shock, or heartfailure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		S a consecutive	Juence of):	ANTE	1 EA	Pi	17 1512	ALUK SE	26			Interval Between Onset and Death
P.O. Box 687	the death certifi by the attending ached for use as	Physician/Medical	in the past 12 months?  1 Yes 2 No 9 Unknown	a. 23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta at time of c	ldeath 3[ leath 5[	∃Ectopic pro ∃Other (spe	ecify)					23d. Date Mor	e of delive	ry Day Year
ś	res tha iigned be del	by	Part II. Dther significant conditions co	entributing to death	but not res	ulting in the u	nderlying ca	ause give	n in Part I.				_		e cause of death?
ord	w requir been si should	ted	· · · · · · · · · · · · · · · · · · ·								1	Yes 2	2 🗆 No	3 Prob	ably 4 SUnknown
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₹	sicial certii recto	o Be	25. Was case referred to medical examiner?	Hospital:			_	Othe			Check onl		-		
ō	Phys r this ral di	$\vdash$	1 Yes 250No 27. Manner of Death	1 🗆 Inpat		ER/Outpatier		^ ]	4 2010		me 5 Res 28d. Describe				)
O	ding F h. After funera	ton	Natural 5 Pending	28a. Date of Inj (Month, D	ay Year)	Injury	м .	8c. Injury Work'	? es 2 □ 1		Loc. Dosono	, 110 W 1111	ary occurre	54	
Divisi	or At	Certification:	2	28e. Place of Inbuilding, e	ijury - At h					pie		(Street a own, Stat		ar or Rurai	Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical (	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	rsician: To the bes iner: On the basis and manner s	of examina	wiedge, deatl ition and/or in	n occurred a vestigation,	at the time in my opi	e, date and inion, deat	d place, a	and due to the	e cause(s	s) and mar nd place, a	ner as stand due to	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	<i>C</i> .	1011			License					ate signed		Day, Year)
)			Solar	de Si	NOUF	t MUV	THE	L	, 2i	フフト	-	MAY	19	, 25	005
	6		30. Name and address of person who co		^	n 23a) (Type,	Print)	= t	IWY	00	BAUC	NA.	M	0	21122
	Sta	te ar	31. Date filed (MoVh Dry, 204) 201	)5 Regist	trar's Sign	ture de	de				,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 10c per fh 9843 5-20-05 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician HILLERI mar 11745 A 2003 /Medical 4a. Facility Name (If not institution, give street and number. 4b. City, Town, or Location of Death 4c. County of Death Examiner H e nns nia (51 DY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral**  Birthplace (State or Foreign Country) 1 M 2 F 215.03.1487 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Parkville 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Mudical Examinar must be notified at 1 Yes 2 □ No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American I Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status American Indian 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than '' any injury or other traumatic avent Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) HARIHORN AVE MICHAEL JOHNSON NEPHEW 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility EVAN 21. Signature of Funeral Service Licensee 101220 LARKVILLE, MD 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 0 MM disease or condition resulting in death) /Medical Due to (or as a consequent **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit Due to (or as a consequence of): Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 10 3 Probably 4 Unknown 1 🗋 Yes director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has certificate I 1 Yes 21 No 21 No 1 🗆 Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certified 29d. Date\signed (Month, Day, Year) 30. Name and ad ress o completed cause of death (Item 23a) (Type, Print)

Registrar

State

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Burnsy, m) 2/06/

		ļ	For State	State of Mary	•	artment of H		Mental Hygie	ONAR	
			Registrar  1. Decedent's Name (First, Middle, La	stl	061	illicate of	Dealli	Reg.	No.	3. Time of Death
	Physici	an	D	11/2-	T 1-	110-	•	Month	Day Year	м
	/Medio		4a. Facility Name (If not institution, giv	street and number)	1	4h City Town o	or Location of De		16, 2005 4c. County of Deatl	
	Examir		2503 VIOLET AVE	3,1001 Bita Hambor)		BALTIMO		4411	A.	)/4
	Funeral		5. Social Security Number 6. S	ex 7. Age (li	n yrs., last birthday)	If Under 1 Year	If Under 24 H		9. Birth	nplace (State or Foreign
	Director		219-26-7042	□ M 2 <b>X</b> F	65 Yrs.	Months Days	Hours Mi	n. (Month, Day, Ye	1941 Co	A-RV/A-NA
			Usual Residence of Decedent						770171	TYLAND
	how		10a. State 10b. County		c. City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f s	cto	MARYLAND /	UIA		$\mathcal{L}_{\mathcal{L}}$	ALTI	MORE C	ITY	1 X Yes 2 No
	ith th	Dire	10e. Street and Number	-		10f. Zip Code	411	10g.	Citizen of What Co	untry?
	death with the Maryland ms 23a or 28a-f show IT-USI be notified at	Funeral Director	2503 VI	OLET AVE			2/2	15	451	<del>7</del> ·
	tams	une	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Amer Black, White	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married  3. ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 <b>X</b> No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: 12	0000
5-0036	72 hours after neturel', or Ita lical Examina	ed t	15. Decedent's E		16a Dece	dent's Usual Occup	nation	166	. Kind of Business/l	Industry
215	in 72 "ne feutic	Completed	(Specify only highest gra	de completed)	(Give	kind of work done DO NOT use retire	during most of w	rorking	. Nind of businessri	industry
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	e filad within at Hygiene. I other then '	BeC	17. Father's Name (First, Middle, Last,					ame (First, Middle, Maid		
a	fental fental rked c	To B	ABRAHAM		WATT		ROS	EMARY	SCH	AE FER
Maryland	2 shou and N is mai	-	19a. Informant's Name/Relationship (			ng Address (Street	and Number or	Rural Route Number, Cit	ty or Town, State, Z	ip Code)
	is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other then "neturel", or Itams 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at		DONNA POWEL	GRAND DAUGI	HER) 414	12 BROI	WNBAH	RK CIRCLE K	ANDALLSTOO	WMD. 21133
altimore,	es 1 and 2 of Health fitem 27 i		20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐		20b. Place of Dispo	sition (Name of matory or other pla	ce)		Location - City or	
<u>E</u>			'4 □Donation 5 □ Other (Specif		HETRO C	REMATO.	RY15-	19-05 R	PALTIMOR	E. HD.
a	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Lices	1500 ) '//	1 , 22	2. Name and Addre	ss Facility	BRANDA	JR. FUN	ERAL HOME
<u>m</u>	89 = 9		Withich	N. Wille	ams &	21451	J. FULT	ON AVE. &	ALTO, M	021217
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not ent	ter the mode of dyi	ng, such as card	ac or respiratory arrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	, HYPERTENS:	IVE ARTER	IOSCLERO	TIC CARE	IOVASCULAR	DISEASE	Onset and Death
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	xacut and Il-tran	Examin	that initiated events resulting in death) Last	c. Due to (or as a co	onsequence of):					
8760	cate ba exacuted bhysician and the burial-transit	alE		,	. ,					
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Box (	death certific e attending p d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p					23d. Date of deli	verv
B	leath atter	ciar	in the past 12 months?	1□Live birth 2□ 4□Pregnant at tim		∃Ectopic pregnanc; ∃ Other (specify) _	у		Month	Day Year
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	w requires that the baen signed by the should be detache	by P	Part II. Other significant conditions of	ontributing to death but n	ot resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tobaco	o use contribute to	the cause of death?
Records,	quire in sig uld b	a pe						1 ☐ Yes	2 No 3 Pro	obably 4 Kunknown
0	- Q 70	Completed						24a. Was an	24b. Were aut	topsy findings available
Re	The faw ata has page 2 s	шо						autopsy performed 1 ☐ Yes 2 ☐X	? death?	ompletion of cause of
Vital	icien: Th certificata rector, pag	Φ	25. Was case referred to medical				26. Place of D	eath (Check only one)	10 103	2010
<u>&gt;</u>	Physicien: this certific ral director,	To B	examiner? XXYes 2□No	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3 DOA Ott		Home 5 ☐ Residence	6 X Other (Spec	ity) SCENE
J of			27. Manner of Death  XXNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	f 28c. Injui Wor		28d. Describe how in		J. DOLLIE
Ö	Attending I r death. actor: After by the funer	atlo	2 ☐ Accident investigatio	1	nijary		Yes 2 □ No			
Division	er de racto	tific	3 Suicide 6 Could not b	28e. Place of Injury building, etc. (5	- At home, farm, str Specify)	eet, factory, office		28f. Location (Street City or Town, St	and Number or Rui ate)	ral Route Number,
	rs after al Dir	Certification:								<u> </u>
	Hospital		(Check only 2 Medical Example (Check only 2 Medical Example )	ysician: To the best of m niner: On the basis of ex	amination and/or in	h occurred at the til	me, date and pla	ce, and due to the cause	e(s) and manner as	stated. to the cause(s)
	To the Hospital or Attend within 24 hours after death To the Funeral Diractor: completely filled in by the	Medical	one)	and manner stated		29c. Licens			Date signed (Month	
	To Your	-	29b. Signature and title of certifier	200				290.1	Date signed (MONIT)	, way, rear)
	1		routin	-1900el	- 2		ME	MAY	17, 2005	
	3		30. Name and address of person who PATRICIA ARONICA-I		ı (item 23a) (Type,		nn Stro	et Baltimore	a Marulan	d 21201
	Sta	_			Signature A	### 1G	THI DELEG	- Dar CIMOL	- rary rall	G 21201
	Pomist		31. Date filed (Month, Day, Year) MAY 2. 0 200	1 Marchael	J. 13034					

Registrar
DHMH 17 Rev 1/2001

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Penn Street Baltimore Maryland 21201

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32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 18, 2005 April 10:25 a May Jones /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Martins Home Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 5 Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 M 2 TF Director 220-54-8462 15, 1907 | Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10b. County 10d. Inside City Limits 10a. State 28a-f show other traumatic avant, the Medical Examinar must be notified at Maryland Baltimore 1 ☐ Yes 2 ➡No Catonsville Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 0 Items 23a 601 Maiden Choice Lane 21228 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩ No Specify: Specify. White 3 Widowed 4 Divorced Year or Dates "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be fill and Mental H Be (Unknown) (Unknown) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health itam 27 825 Eastern Blvd., Baltimore, MD 21221 Deborah M. Engram (PR) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ Department of Important: If any injury or once. \* 4 □ Donation 5 □ Other (Specify) Loudon Park Cemetery 4/20/05 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a Darth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician INEUMONIS TWOWEERS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its today or injury Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ło in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation Injury 2 **N**No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 9 A after death. 1 Yes 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 6 Could not be in by determined 4 Homicide 601 Moridan Choice NURSING filled Mong within 24 hours a To tha Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 211171 APRIL 19,2005 39335 whashave Ellicor ( ity MARY LAN) = P-William Some 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAY 2 0 2005

			1 - For Stete Registrar	State of I	Marylan		artmen rtificate					iene 99. No.	005	17051
	Physicia	an	Decedent's Name (First, Middle	, Last)						2.	Date of Deat Month	h Day	Year	3. Time of Death
	/Medic		Sam		ogut						May 10,	_		2:25 A M
	Examin	er	4a. Fecility Name (If not institution		•				Location	of Death			nty of Death	
			Lorien Nursing 5. Social Security Number		Age (In yrs.	last birthday)	Col	umb:	ia If Under	24 Hrs. 8	Date of Birth	Н	oward	place (State or Foreign
	Funeral Director		115-05-2090	1 <b>X</b> M 2□F	86		Months	Days	Hours	Min.	Month, Day, eb 23,	Year)	New	place (State or Foreign intry) York, NY
	ס		Usual Residence of Decedent								20,		1 21011	1011, 111
	anylan show	_	10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	8e-f	ecto	NY Nassa	ıu	New	Hyde								1 ☐ Yes 2 🔯 No
	with the		10e. Street and Number				10f. Zip					-	of What Cou	intry?
	eath	erai	34 Daley Street	12. Was Decede	nt Ever in II	S 13		LO40	ispanic Ori	igin? (Specifi		JSA 14 F	Race - Ameri	can Indian
<b>'</b> 0	r Iten	Funeral Director	1 □ Never Married 2 □ Marri	Armed Force	s?						y Yes or No- can, etc.)		Black, White	
21215-0036	al', o	þ	3	If Yes, Give Year or Date	s:		1 ☐ Yes 2	2🔯 No	Specify:			Spe	city: W	hite
5	72 hc natu	eted	15. Decedent (Specify only highes	's Education t grade completed)		∣ (Give	dent's Usua	rk done d	durina mos	st of working		16b. Kind of	f Business/Ir	ndustry
2	han "	mpi	Elementary/Secondary (0-12)	College (1-4d	or 5+)		DO NOT us		•	J		D 1	T2 1-	
22	illed v Hygie ther t nt, th	Be Completed	12 17. Father's Name (First, Middle, I	Lasti		Seli	Emp1	Loye		er's Name (F	First, Middle, M		Esta	ce
au	ould be filed within 72 hours after death with the Maryland Mental Hygiene. erked other than "natural", or Items 23e or 28e-f ehow atto event, the Medical Examinar must be notified at	To Be	William Kogut								Schwart		<i>(4.176)</i>	
37	should and Men marke	F	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rural R	loute Number,	City or Tox	vn, State, Zi,	o Code)
ž	and 2 ealth a n 27 Is		Mark J. Flanzra	ich - Son		34 I	aley	Str	eet N	ew Hyd	ie Park	, NY	11040	
ore	of He of He liter		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation	2 Domewal from Sta	20b. P	lace of Dispo emetery, crei	sition (Nam	ne of ther plac	e)	Date	9 2	20c. Locatio	n - City or T	own, State
Ĕ	Pages ment of h ant: If ite ury or of		`4 □ Donation 5 □ Other (Sp		no I	h Mose				5/11/0	)5	Pinel	awn, 1	1X
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f ehow any injury or other traumatic event, the Medical Examinar must be notified at one.		21. Signal re o Funeral Service I	Licensee	rein	B 22	Name and the Sh	d Addres 1aloi Ltht(	ss of Facility m Cha Own B	pels, ypass	Inc. Smith	town,	NY 1:	1787
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that causonly one cause on each	sed the death n line.	. Do not ent	er the mode	e of dyin	g, such as					Approximate Interval Between
H	Priysician		Immediate Cause (Final disease or condition	a	RLADI	DER	CA	NC	ER					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	uence of):								
	3 - 11	<u>-</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or	as a consequ	ieuce of).	4 14					_		
	uted d ansit	Examiner	Cause (Disease of Injury											
ó	exection and and rial-tra	Exa	that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of):								
8760,	cate be executed physician and the burial-transit	dicai		d:										
မ	ing ph		IF FEMALE:											
Вох	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as to	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor	2 Fetal	death 3	Ectopic pre						Date of deliv Month	ery Day Year
Ö	that the de ed by the a detached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnani 9□Unknowr		eath 5L	Other (spe	өсту)						
σ.	res that the igned by be detac		Part II. Other significant conditio	ns contributing to deat	h but not resu	ulting in the u	nderlying ca	ause give	en in Part I		23e. Did tob	acco use co	ontribute to t	he cause of death?
ds	quires n sign	d by									1 🗌 Ye	s 2 🗆 No	3 ☐ Prol	pably 4. Onknown
Vital Records,	s been si	Completed									24a. Was an		b. Were auto	opsy findings available
Re	The lav	E O									autopsy perform 1 ☐ Yes 2		death?	mpletion of cause of
ta	ysiclan: The	BeC	25. Was case referred to medical examiner?				1		26. Place	of Death (C	heck only one			20.10
	Physic this ce al dire	10	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpa		ER/Outpatien	t 3□ DO	A Othe	9r: 4 🖪 Nu	rsing Home	5 🗌 Resider	nce 6 🗆 C	Other (Specia	(y)
n	ng f	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	3	njury Day Year)	28b. Time of Injury		Bc. Injury Work	</td <td></td> <td>I. Describe how</td> <td>w injury occ</td> <td>urred</td> <td></td>		I. Describe how	w injury occ	urred	
<u>s</u>	uttendi death. ctor: A y the fu	icat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ot be	Injune At ho		M		Yes 2⊡	_	Logation (Str	not and Mu	mbor or Rus	al Route Number.
Division of	I or Attendater deati	Certification:	4 ☐ Homicide determi	ned 28e. Place of building,	etc. (Specify	()	eet, factory,	, onice		201.	City or Town,		noer or Aura	ar Aoute Number,
	Hospital 24 hours a Funerel stely filled		29a. Certifier 1 Certifying	g Physicien: To the be	st of my know	wledge, death	occurred a	at the tim	ne, date an	d place, and	due to the car	use(s) and	manner as s	tated.
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	(Check only 2 Medical E	xeminer: On the basis and manner	s of examinat	tion and/or in	vestigation,	in my or	oinion, dea	th occurred a	at the time, da	te and plac	e, and due to	o the cause(s)
	To the H within 24 To the F complete	ž	29b. Signature and title of certifier	Л					number		29	d. Date sig	ned (Month,	Day, Year)
	,		aly Chelo	me m	15		10	000	605	60	1	My 1	0, 20	10 S
	6		30. Name and address of person	1	0		Print)			. Al.	~. 0	^		were, my
			PANKAJ K-f- 31. Date filed (Month, Day, Year)	ETERCAL BOOK	atendo Ciano	Name a	SACK	_ K	IVER	IVE	UK ILA	· , 13,	ALTIN	wire, my
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		7		The Manual Street	_	-								

			For State Registrar	State of Ma	aryland /		artment of H tificate of		d Mental H	lygiene Reg. No	2005	17052
	Physici	an	1. Decedent's Name (First, Middle, L	,					2. Date of Month	Death Da	Year 2066	3. Time of Death
	/Medio		BENNY I. K 4a. Facility Name (If not institution, g	ING ive street and number)			4b. City, Town, o	r Location of D		40	. County of Dear	7 / //
	Examili	C1	Franklin Squ	eare Ho	Stite	21	Rose	dal.	9	18	Ba1+.	morp
	Funeral				e (In yrs. last b		ff Under 1 Year Months Days	Hours	Min (Month.	Birth Day, Year)	9. Birt	thplace (State or Foreign
	Director		230-24-7559	1 <del>∏</del> M 2□F	79 	Yrs.	,		5–16	-1926	VI	IRĞINIA
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
	Mary -f sh	tor	MD BA	LTIMORE			ROSED	ALE				1 ☐ Yes 2 🛣 No
	d within 72 hours after death with the Maryland jiene. I than "natural", or Itams 23a or 28a-f show It a Madical Examinat must be notified at	Funeral Director	10e. Street and Number 908 ROSEDALE A	VENUE			10f. Zip Code	1237		10g. Ci	tizen of What Co	ountry?
	ms 23	era	11. Marital Status	12. Was Decedent	Ever in U.S.	13. \	Was Decedent of F	lispanic Origin	? (Specify Yes or	No-	14. Race - Ame	
36	rsafter ( r, or Itan	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏋 Divorced	Armed Forces?  1 X Yes 2 1  ff Yes, Give Year or Dates:	No	1	f Yes, specify Cub 1 ☐ Yes 2X No		uerto Hican, etc.)		Black, Whit Specify:	WHITE
21215-0036	2 hou	ted k	15. Decedent's	Education		a. Deced	dent's Usual Occup	pation		16b. K	(ind of Business	
215	within 7% ene. than "na	Completed	(Specify only highest of Elementary/Secondary (0-12)	grade completed)  College (1-4or :	5+)	(Give life. l	kind of work done DO NOT use retire	during most of d)	working			
	filed with Hygiene. Ither thai	Con	12	2		RADA	R CALIB	T	SPECIAL			CONTRACTOR
Maryland	tal ba	To Be	17. Father's Name (First, Middle, La CARLOS D. K						Name (First, Mid LIZA A.		1 Sumame) (ROBINET	TE)
Mary	de la la		19a. Informant's Name/Relationship PATRICE SAYLOR/				ng Address (Street ROSEDALE			nber, City		Zip Code) 237
altimore,	Pagas 1 and 2 nent of Health a int: If item 27 is iry or other tran		20a. Method of Disposition 1 Burial 2 ☐ Cremation 3	☐Removal from State	cemei	tery, crer	sition (Name of matory or other pla OF FAITH		Date - 19-200		ocation - City or	
Baltin	permit. Pagas Department of Important: If i any injury or once.		4 ☐ Donation 5 ☐ Other (Spe	1	- Caro	22	. Name and Addre	ss of Facility	VACH/ROS	SEDALI	E FUNERA	L HOME
	40260		23a. Part1. Enter the disease, or co	omplications that cause	d the death. D		211 CHES				LE, MD	21237 Approximate
	Pnysician		shock, or heart failure. List on Immediate Cause (Finaf disease or condition				Pathy	.9, 555		, 4.1001,		Interval Between Onset and Death
8.	/Medical Examiner		resulting in death)		a consequenc	e of):						
	ted nsit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b. Due to (or as	a consequenc	e of):						
, 0	ata be exacuted hysician and the burial-transit	i Examine	that initiated events resulting in death) Last	c. Due to (or as	a consequenc	e of):						
8760	ata the	dica		d.							_	
Box 6	eath certific attending pl	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			7				23d. Date of del	livery
O. B.	the the	Physician/Medical	in the past 12 months? 1  Yes 2 No 9 Unknown	1□Live birth 4□Pregnant a 9□Unknown			Ectopic pregnanc Other (specify)	y		-	Month	Day Year
Δ.	that the	by Ph	Part II. Other significant conditions	s contributing to death t	out not resulting	j in the u	nderlying cause giv	ven in Part I.	23e. D	id tobacco	use contribute to	the cause of death?
rds	quires n sign	q pe	End Storge	Kenal	dise	e as	e			Yes 2	□No 3□Pr	robably 4 Unknown
Vital Records,	aw requir as been si 2 should	mpleted							24a. W	as an utopsy	24b. Were au	utopsy findings available
R	The la ate ha	0								orformed?	death?	completion of cause of
ta	ician: Tertifical	Be C	25. Was case referred to medical examiner?					26. Place of	Death (Check or			
of V	N S	To	1 ☐ Yes 2 ☑ No	Hospital: fnpation			IL SU DOA		ng Home 5 🗆 R			city)
no O		ion:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju (Month, Da	iry 28b iy Year)	. Time of Injury	Wo	rk?	28d. Descri	oe how inju	ry occurred	
Sic	ten feat for: the	icat	2 Accident investigat 3 Suicide 6 Could not	be as Phon of the	iun. At home	farm etr	M 1 C	Yes 2 □No	28f Locatio	n (Street a	nd Number or Ri	ural Route Number.
Division	or Attendated after death	Certification:	4 Homicide determine	building, et	c. (Specify)	iaiii, sti	eet, ractory, onice			Town, State		na House Namoor,
_	Hospita 4 hours Funeral ely fillec	edical C	29a. Certifier 1/2 Certifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis of and manner st	of examination a	lge, death and/or in	n occurred at the ti vestigation, in my o	me, date and popinion, death of	place, and due to occurred at the time	he cause(s ne, date an	and manner as d place, and due	s stated. If to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Da	ite signed (Monti	h, Day, Year)
	->-0		1 1 June +	7-A.H.	( MO		126	125	1	5	/16/05	
	. (		30. Name and address of person wh	no completed cause of (	death (Item 23a	a) (Type,	Print)			,		
	4		Dr. Wassint1	- Hitti 9	500 F	ran	Klin 59	hore.	Drive B	0-111	mole, M	121237
	Sta Registi		31. Date filed (Month, Day, Year)	2 1 2005 Registr	s Signature	15	pode	•			,	

				artment of Health and Me rtificate of Death	ental Hygie Reg.	ZHII5 17053
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici		Edith E	Kelbaugh	Month May 19.	Day Year 2005 1:00 A M
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Genesis Eldercare Hammonds Lane	Linthicum		Anne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.   8   Months   Days   Hours   Min.	B. Date of Birth (Month, Day, Ye	9 Birthplace (State or Foreign
	Director		213-18-9866 To Market State St		Aug. 1,1	
	land ow		10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	Many	tor	Maryland Anne Arundel Glen Bur	nie		1 🗆 Yes 2 🗔 440
	or 28s	irec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	death with the Maryland ms 23a or 28a-f show [ust be notified at	Funeral Director	6505 Dolphin Court	21061		U.S.A.
	tems	ne	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.
9	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or items 23a or 28a-f show event. Its Medical Extrail etc. ast be redified at	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Mo If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify:
-003	hour hural	edk		dent's Usual Occupation	16h	White Kind of Business/Industry
<u>.</u>	filed within 72 Hygiene. Ither than "na Int, Ita Medic	Completed	(Specify only highest grade completed) (Give life.	kind of work done during most of working DO NOT use retired)	'	. Title of basilloss massay
7	giene giene er tha	mo:		ookkeeper		Car Dealership
and	be file ital Hy id oth	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name (	First, Middle, Maid	den Sumame)
Х	should by nd Menta marked	우	Homar L. Nutti			Thompson
Mar	2 sar ar a			ng Address (Street and Number or Rural I		
e)	1 and Health Bm 27 ther ti		Doris L. Shaneor (Daughter) 6505  20a. Method of Disposition 20b. Place of Dispo	Dolphin Court Glen		Mary land 21061  Location - City or Town, State
פֿ	Pages nent of i int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	matory or other place)		
ашшо						ltimore, Maryland
Ď	permit. Departr Imports any inju		both F Collins 13	2. Name and Address of Facility CCully—Polyniak Fun 204 Mountain Road P	eral Hom	e, P.A.
Ħ			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.			Approximate Interval Between
L	Physician		Immediate Cause (Final disease or condition	In Combins		Onset and Death
	/Medical		resulting in death)  a. Due to as a consequence of):	Marsichan		
	Examiner		Sequentially list conditions b.			
V	Si ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
	ecute and I-tran	Examin	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):			
0/00	cate be executed physician and the burial-transit	al E				
	ficate g physi as the	edical	d.			
Š	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	lan/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetel death 3 □			23d. Date of delivery
	death	sicla	1 Yes 2 No 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month Day Year
5	at the	Physicia	9 🗆 Onknown			
'n	res th signed be d	ğ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		o use contribute to the cause of death?
corus,	requi	eted	CITO STAGE CEIVELLY	3	1 🗆 Yes	2 No 3 Probably 4 DUnknown
ב	a si	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
NICAL N	n: Th ficate or, pag	ပို	OF Was and salved to madical		1 ☐ Yes 2	
=	sicia s certi lirecto	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	26. Place of Death (control of the control of the c		6 ☐Other (Specify)
5	g Phy er this eral d	$\vdash$	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at 28c	d. Describe how in	
NISION	ath. r: Aft	atio	1 Matural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
<u> </u>	r Atte er dea racto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 28	Location (Street City or Town, St	and Number or Rural Route Number,
5	ital or ris after ral Di	Ce				
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier (Check only one)  12 Certifying Physicien: To the best of my knowledge, death of the basis of examination and/or in and manner stated.	h occurred at the time, date and place, and vestigation, in my opinion, death occurred	d due to the cause at the time, date a	(s) and manner as stated.  Ind place, and due to the cause(s)
	To th within To the	Me	29b. Signature and title of certifier	29c. License number	29d. [	Date signed (Month, Day, Year)
			M MA	D53462		5/20/01
	/		30. Name and address of person who completed cause of death (Item 23a) (Type,			21061
	ン		Jude Money MA 7845	OHYWOOD KOA	t Olen	Burnie ma
	Sta Registra	-	31. Date filed (Month, Day, Year)  MAY 2 0 2005  32. Registrar's Signature	- ASP 6		
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DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Man		artment of H			giene Reg. No. 0	15	17054
	Physici /Medio		1. Decedent's Name (First, Middle, Las Wanda Kyle	)				2. Date of Dea Month May		2005	3. Time of Death
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of D	eath	4c. County		
			Cherry Lane Nurs 5. Social Security Number 6. Se		n yrs. last birthday)	Lau If Under 1 Year	re1	Hrs. 8. Date of Birt			George's
	Funeral Director		214-34-4787	_M 2X1F	69 Yrs.	Months Days		Min. (Month, Da Mar. 23	v Year)	Penns	lace (State or Foreign try) sylvania
	pu *		Usual Residence of Decedent  10a, State 10b, County	11	Dc. City, Town or Lo	cation					Od. Inside City Limits
	Maryla f sho	ō		George's		aurel					1 Yes 2 No
	r 28a-	rect	10e. Street and Number	3000		10f. Zip Code			10g. Citizen of V	What Coun	try?
	th with	ai D	9001 Cherry Lane			20	708		United	State	:S
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28a-f show aumatic event, Ita Medical Evantinar must be rediffed at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Origin? In, Mexican, Pu Specify:	? (Specify Yes or No- uerto Rican, etc.)		e - America k, White, a Whit	etc.
Maryland 21215-0036	"natura	Completed	15. Decedent's Ed (Specify only highest grad	ucation	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of	working	16b. Kind of Bu	usiness/Ind	ustry
7	l withir iene. r than	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)		al <b>t</b> h Care	<i>'</i>	ler	Hea1	th Ca	.re
מ	al Hyg al Hyg I other vent,	Be C	17. Father's Name (First, Middle, Last)					Name (First, Middle,	Maiden Sumam	(8)	
ylaı	ould b Menta	To	Unknown					nia Ellen			
Mar	es 1 and 2 should b of Health and Ment i itam 27 is markac ir other traumatic e		19a. Informant's Name/Relationship (7) Sharon Sainz Dau	<sub>урв, Print)</sub> ghter	1			Rumal Route Numbe Baltimore,			Code)
ď.	s 1 and f Health itam 27 othar tr		20a. Method of Disposition		20b. Place of Dispo cemetery, crei			Date	20c. Location -		wn, State
Ē	Pages nent of I int: If its	/	1 ☐ Burial 2 XCremation 3 ☐ ☐ Conation 5 ☐ Other (Specify	Tollioval Ilolli State				5-21-2005	Baltime	ore,	MD
Baltimore,	permit. Pages Department of Important: If it any injury or o	(	21. Simalure of Funeral Service	10 Dec	1 1//0/ 22.6			Ambrose Fu Lng Rd., A		-	
Ī	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	static		,	Canc			Approximate Interval Between Onset and Death
8760, 🗞	death certificate be executed by the attending physician and but of or use as the burial-transit but	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a co							
O. Box 68	death certifi e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mor	e of deliver	ry Day Year
ecords, P.	The law requires that the te has been signed by the rage 2 should be detached.		Part II. Other significant conditions co	ntributing to death but n	ot resulting in the u	nderlying cause give	en in Part I.			ibute to the	e cause of death?
		Completed by						24a. Was a autop perfor	med? d	rior to com leath?	sy findings available interior of cause of
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe		Death (Check only or			
on of	ding Phys h. After this funeral di	tion; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient  28a. Date of Injury (Month, Day Ye	2 ER/Outpatier 28b. Time of Injury	28c. Injury Work	IAMISITI	g Home 5 Resid	ence 6 Othe		
Division	tal or Attandi s after death. al Diractor: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (\$	- At home, farm, str Specify)	eet, factory, office		28f. Location (S City or Tow	itreet and Numbern, State)	er or Rural	Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Dirac completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Phyone) 2 Medical Exam	sician: To the best of miner: On the basis of ex and manner stated	amination and/or in	occurred at the time restigation, in my op	ne, date and pla pinion, death o	ace, and due to the occurred at the time, o	ause(s) and mar date and place, a	nner as sta and due to	ted. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	11/00		29c. License			29d. Date signed		
	2		30. Name and address of persol o c	ompleted cause of death	n (Item 23a) (Type,	Print)	11.	35 ne 19	2118 2, m	105	0
N.	Sta Registr		31. Date filed (Month Day, Year) MAY 2 0 2005	32. Registrar's	Signature		Tymo	re M	ve,	La	unel

DHMH 17 Rev 1/2001

		Registrer  1. Decedent's Name (First								2. Date of De	ath	<del>2005</del>	3. Time of Death
Physic /Medi		Da'Quan		Lippmar						May 16	-		8:54 A M
Exami	ner	4a. Facility Name (If not in Johns Hopki)			ber)		Balt	Town, or Loc imore	ation of Dea	ath		County of Dea	th
Funeral Director		5. Social Security Number 217–71–4419	15	X	7. Age (In yrs. I	ast birthday) Yrs.	If Under Months 4		Under 24 Hr ours Mi		y, Year)	C	thplace (State or Foreign ountry) MD
and and		Usual Residence of Deced 10a. State 10b.	dent County	-	10c. City	, Town or Lo	cation						10d. Inside City Limits
ith with the Marylan 23a or 28a-f ahow ust be notified at	Ď	MD	N/A			Baltim	ore						M2XYes 2 □ N
ith the M or 28a-f e notifie	Director	10e. Street and Number					10f. Zip	Code			10g. Citiz	en of What Co	ountry?
23a c		2536 E. Fa	ayette	Street			2	1224				USA	
s after des or items	by Funeral	11. Marital Status 1   Marital Status 2 3  Widowed 4 □ D	_	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Da	ces? 2 No		Vas Deced fYes, spec I□Yes 2		nic Origin? ( lexican, Pue pecify:	Specify Yes or No irto Rican, etc.)		4. Race - Ame Black, Whit Specify: B1	
72 hours neturel'; dical Ex			ecedent's Ed			16a. Deced	lent's Usua	I Occupation	1		16b. Kir	d of Business	~
d within 72 hogiene. sr than "netu	Completed	Elementary/Secondary N/A		de <i>completed)</i> College (1- N/A	4or 5+)	life. L		rk done durin se retired)	g most of w	orking		N/A	
ba filed Ital Hygid Id other event, I	Be	17. Father's Name (First,						18.		ame (First, Middle,	Maiden :		1000
2 should ba I and Menta! I Is markad or raumetic eve	ပို	Maurice		oman					Danie			Branch	
d 2 sho th and 7 Ismu traum		19a. Informant's Name/Re Danielle Bra				16	-			Rural Route Numbe Baltimore			
Pagas 1 and 2 should nent of Health and Men int: If item 27 Is marka iry or other traumetic		20a. Method of Disposition 1 Burial 2 Crer	1	-		lace of Dispo emetery, cren	sition (Nan	ne of		Date		cation - City or	
it. Pa rtmen rtant: njury		`4 □Donation 5 □ C			Gr	eenmou	-		F00-	0/2005		timore	
permit. Page Department of Important: If any injury or once.		21. Signature of Funeral S	Service Licens	Wo				d Address of	[4]	ARCH FUNI enue Balt			AST 21202
or Attending Physicien: The law requires that the death certificate be axecuted to the death.  Very Carlot of the certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit in page 2.	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immedia auts. Little University Cause (Disease or injury that initiated events resulting in death) Last	s,	Due to (c	n Unexpor as a consequence or a consequence or as a consequence or as a consequence or as a consequence or a cons	uence of): uence of):	Deat	h in I	Infanc	У			Onset and Death
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quires that n signad t uld be det	by	Part II. Other significant of	conditions co	entributing to dea	ath but not resu	ulting in the ur	nderlying ca	ause given in	Part I.		bacco us		o the cause of death? obably 4 DUnknov
n: The law requir ficate has been si or, page 2 should	Completed	25. Was case referred to	modinal						Dis(D		sy med? 2 No	death?	utopsy findings availate completion of cause of 2 No
ysicien: is certific director,	To Be	examiner? XXYes 2 No	-	Hospital: 1 ☐ In	patient 2	ER/Outpatien	3 DO	Othor		Home 5 Resid		Other (Spe	cify)
Attending Phydeath. ctor: After thi		27. Manner of Death  1 Natural 5 2 Accident	Pending investigation	Found 5-16-	n, Day Year)	28b. Time of Injury	unk 2	Work?	2 <b>X</b> No	28d. Describe h	ow injury	occurred	unk
tel or Atters after de BI Directo	Certification:	3 Suicide 6 X 4 Homicide	Could not be determined	200. Flate	of Injury - At ho g, etc. (Specify	me, farm, stre	eet, factory	, office		28f. Location (S City or Tow Baltimo:			ralRoute Number r <b>lean</b> s Str
= 5 S =	edical	29a. Certifier 1 C (Check only 2:X N one)	ertifying Phy ledicel Exem	sicien: To the l	best of my kno- sis of examinal	wledge, death ion and/or inv	occurred a restigation,	at the time, d in my opinio	ate and place n, death occ	ce, and due to the courred at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s)
ha Hosp in 24 hou he Funa pletely fi	Σ	29b. Signature and title of	certifier				29c	License nu				signed (Mont	
To the Hospitel or within 24 hours after To the Funeral Dire completely filled in b	-	30. Name and address of	es L	~				OCME			ray	<b>17</b> , 20	105

		,	For State Registrar	, 1040	State o	f Marylar	nd / Dep		t of H	lealth a	and M	lental Hy	giene	05	17056
	۰	46	Decedent's Name	(First, Middle, L	ast)							2. Date of De	ath		3. Time of Death
	Physici		BRUCE	W.	LOHMAI	N.						Month	15 Z	.005	330 AM
	/Medic Examin		4a, Facility Name (If	not institution, g	ive street and nu	mber)		4b. City,	Town, or	r Location	of Death	111001	4c Coun	ty of Death	
			trankli	n Sawa	ure Hos	DITAL		1 BO	Seal	le			M	Himor	e
	Funeral		5. Social Security No		Sex. 1☐M 2☐F	7. Age (In yrs.		) If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir	th v. YearL	9. Birthp	lace (State or Foreign
	Director		218 56	0030	16 M 20 F	5	4 Yrs.	, mortus	Duys	7.00.0		0 4 9 1 9	71951	KEN:	ľÚCKY
	pu 🖈		Usual Residence of 10a. State	Decedent 10b. County		10c C	ity, Town or L	ocation							Od. Inside City Limits
	lanyla sho	٦	MD		TMODE	100. 0	•		e pr	כויבוע ז					1 □ Yes 2 No
	ith the Marylan or 28a-f show	ecto	1		TIMORE			MIDDL		VER	_		10g. Citizen of	14/hat Cau	
	ath with the Maryle 23e or 28e-f show	ā	10e. Street and Nun		V CTE			10f. Zip	212	20			_	J.S.A.	-
	eath w	Funeral Director	11. Marital Status	NIUM PLA		edent Ever in U	18 13	Was Decer			igin? (Sn	ecify Yes or No		J. D. A.	
	ter dea	-un-		ied 2🛣 Married	Armed Fo	orces?	,	If Yes, spec	cify Cuba	n, Mexica	n, Puerto	ecify Yes or No Rican, etc.)	BI	ack, White,	
036	urs aft	by	3 Widowed		If Yes, Gir Year or D	ve		1 🗆 Yes	2∏No	Specify:	:		Spec	ify: WH	HTE
5-0036	within 72 hours after death with the Maryland ane.  ane.  Then "natural", or liems 23a or 28a-f show in the "natural", or liems 23a or 28a-f show in the "natural".	ted	/5	15. Decedent's	Education		16a. Dec	edent's Usua a kind of wo	al Occup	ation	et of work	ina	16b. Kind of	Business/In	dustry
9	within 7 ene. than "n	ple	Elementary/Second	ify only highest g	College (	1-4or 5+)	life.	DO NOT us	se retired	daring mos	SI OF WORK	my			
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5	be filed ital Hyg id other	Be (	17. Father's Name (			Λ.Τ			İ		er's Nam CTDA	e (First, Middle,			C)
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ohman, Br	gas 1 and 2 should be filed within to the fall and a should be filed within to filed water and water the filed within a 71 is marked other than or othar traumatic event. It a M	8.3	BRENDA S		-			ERMAN					RIVER		21220
OhmA	of Hea	1 8	20a. Method of Disp				Place of Disp	osition (Nar	ne of ther plac	ce)	-	Date	20c. Location	- City or To	own, State
7	Page nent c int: If		1 ☐ Burial 2 ☐	Cremation 3 5 ☐ Other (Spec	□Removal from cify)	State ME	TRO CE	•		1	5-18	3-2005	CATO	NSVILI	E, MD
0 #	permit. Pag Department Important: any injury o		21. Signature of Fu	neral Service	ense		2	2. Name an	d Addres	ss of Facili	ty CV	ACH/ROS	EDALE I	FUNERA	
7	Ped de la serie de				5			1211	CHES	ACO	AVEN	IUE F	OSEDALI	E, MD	21237
			23a. Part1. Enter the shock, or hea	he disease, or co	mplications that of	caused the dea	th. Do not ea	nter the mod	le of dyin	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between
	Pnysician		Immediate Cause ( disease or conditio	(Final	In	ra Cen	beal	hem	ort	hage	,				Onset and Death
	/Medical Examiner		resulting in death)	-	Due to	(or as a conse	quence of):	011		11-1	1		7		2014
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	led sit	Examiner	Sequentially list confrant, leading to imcause. Enter Under Cause (Disease or that initiated events)	rlying injury	000	colline 1	Orland	, the	mul	neic		200	NO.		2 days
V	te be executed ysician and e burial-transit	xar	that initiated events resulting in death) I	Last	c. Due to	(or as a conse	quence of):	/ ////	UTIL		12	XXXXX	166		zaugs
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68											1/	11/1 V	1 *		
Box	leath certificat attending phy	M	IF FEMALE: 23b. Was decedent	t pregnant		tcome of pregr		□ <b>□</b>			-SH	DOX	23d. D	ate of delive	ery
0	death e atte	icla	in the past 12 1 ☐ Yes 2 ☐		4☐ Pregi	oirth 2 Fet nant at time of		□Ectopic pi □ Other <i>(sp</i>					N	fonth	Day Year
0	Hospital or Attending Physician: The law requires that the death certifica 4 hours after death. Funeral Director: After this certificate has been signed by the attending philiply filled in by the tuneral director, page 2 should be detached for use as the filled in by the funeral director.	Completed by Physiclan/Med	9 🗌 Unknown		9□ Unkn	own			-			-			
	as the	by F	Part II. Dther signif	- 1	1 1 -			, ,	ause giv	en in Part I	l.				ne cause of death?
rd	w require	ted	Innomic			ar ana	reph	1				132	Yes 2□No	3 🗆 Prob	ably 4 Unknown
Ü	lawr as be	ple	medias	tinal t	umor							24a. Was autor	SV	prior to cor	psy findings available mpletion of cause of
of Vital Records.	The I	Con										perfo 1 ☐ Yes	med?	death?	2 No
=======================================	ysician: is certific director,	Be	25. Was case refer examiner?	red to medical							e of Deat	h (Check only o	ne)		
7	Physic this o	ပို	1 <b>∑</b> Yes 2□				ER/Outpatie			4 🗆 141	ursing Ho	me 5 Resid			y)
-	ding Ph h. After th funeral	on:	<ol> <li>Manner of Death</li> <li>Natural</li> </ol>	5 Pending	A 4	of Injury nth, Day Year)	28b. Time Injury		28c. Injun Wor		<u>د.</u>	Intro	row injury occi		
	Mttendi death. ctor: A y the fu	cat	2.XAccident 3 ☐ Suicide	investigat	, ici y	13,2005				Yes 2 🔀	ÍNO	Com			Il Route Number,
Division	or Attendate death Director.	ertification:	4  Homicide	determine	build	of Injury - At I	ify)	treet, factory	, office			City or To	m. State)	Squar	e Dr
_	pital ours a eral I	O	29a. Certifier	19 Certifying	Physician: To the		pita	th accurred	at the tin	no data ar	nd place	SGITIMO	RE STY	MARY	ranc (15)
	24 hc 24 hc Fun etely	edical	(Check only one)	2 Medical Ex	aminer: On the b	asis of examin	ation and/or i	nvestigation	, in my o	pinion, dea	ath occur	red at the time,	date and place	, and due to	the cause(s)
_	To the Hospital or vailthin 24 hours after To the Funeral Direct completely filled in b	Me	29b. Signature and	title of certifier		_	^	290	-	e number			29d. Date sign		
	. > - 0		1 To	Sonde	VDOV	- M			De	517	61		5/15	1200	
	10		30. Name and addr	ess of person wit	o completed cau	se of death (Ite	m 23a) (Type	Print)		0	1	-			_
	V		Prasa	a Beti	ldpur,	MD 9	1000 F	rank	la.	Squai	re Di	ZIVE BY	1/1/40re	2, MD	21237
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			For 1 State	JC 1				/ Depa	artmen	t of H	lealth a		lental Hy		9	DIC.		
			Registrar					Cei	rtificat	e of l	Death			Reg. No	.20	105	17	057
	Physicia	an	Decedent's Name (First, Middle										2. Date of Dea	Da	005	Yeer	3. Time/of	Déath' /
	/Medic	al	Curtis Henry La  4a. Fecility Name (If not institution			mher)			4h City	Town or	Location o	of Death	May 18	•		of Death	6:10	P ""
	Examin	er	348 Homberg Ave	-	31,001 2310 110				_	ssex						imore	<u>.</u>	
	Funeral		Social Security Number	6. Sex		7. Age (	in yrs. las	t birthday)	If Under Months		If Under	24 Hrs. Min.	8. Date of Birt (Month, Oa)				face (State o	r Foreign
	Director		174-18-9551	113	<b>{</b> M 2□ F		86	Yrs.	I I I I I I I I I I I I I I I I I I I		110010		Oct. 5,	1918	3	Penr	śylvar	nia
	land w		Usual Residence of Decedent  10a. State 10b. County			1	Oc. City,	Town or Lo	cation							1	0d. Inside Ci	ty Limits
	Mary I-f eh	to	Maryland Balti	more	9		Esse	X									1 ☐ Yes	2 <b>X</b> No
	th the	lrec	10e. Street and Number						10f. Zip		4			_		What Coun	try?	
	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23a or 28a-f ehow event, if a Medical Erier, if at Intal Residential and avent, if a Medical Erier, if at Intal Residential and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second a second and a second and a second and a second and a second a	Funeral Directo	348 Homberg Ave							2122					S.A.			
	er de	nne	11. Marital Status  1 □ Never Married 2 ☑ Marr		12. Was Dec Armed Fo	orces?	erin U.S.	13.	Was Deced If Yes, spec	dent of Hi cify Cuba	ispanic Ori n, Mexican	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	-		e - Americ ck, White,		
38	urs aff	by F	3 Widowed 4 Divorced		If Yes, Gir Year or D	ve			1 ☐ Yes	2 <b>X</b> No	Specify:				Specify	/: Wh	ite	
ဝို	72 hou	ted	15. Deceden (Specify only highe	it's Edu	cation			16a. Dece	dent's Usua	af Occupa	ation	t of worki	ina	16b. K	ind of Bu	usiness/Inc		
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and	be de la la la la la la la la la la la la la	э Ве	Bernard Lange	LB3()							Juli			marcon	Caman	.0)		
Maryland 21215-0036	should be nd Menta marked	То	19a. Informant's Name/Relations	hip (Ty	pe, Print)			19b. Maifir	ng Address	(Street a			I Route Numbe	r, City	or Town,	State, Zip	Code)	
	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		Pearl Olivia La	nge	(Wife							, Es	sex, Ma	ryla	and	21221		
ore	es 1 and of Health If Item 27 or other tr		20a. Method of Disposition 1   ■ Burial 2 □ Cremation	3 □ B	temoval from	State		ce of Dispo netery, crea					Date			City or To		_
Ē	Pages Iment of tant: If It jury or o		*4 □Donation 5 □ Other (S	pecity)			Gard	dens (			1	_	1,2005					nd ———
Baltimore,	permit. Pages Department of Important: If II any injury or c		21. Signature of F ne a≯ Servì	License	90			22	2. Name ar	nd Addres Br	ss of Facility UZQZ1	nski	Funera	l H	ome,	P.A.	3.00	1 221
		The same	23a. Part1. Ent he disease, or shock, eart failure. List	compli	cations that of	caused th	e death.		1407	OTa .	Easte	rn A	venue,	LSS6	∋x,_	Maryı	Approximate	е
	Discontinue		Immediat ause (Final	only or	ne cause on e	each line.	11										Onset and D	
	Physician / /Medical		disease or condition resulting in death)	-	Due to	(or as a c	conseque		an	a								
	Examiner		Sequentially list conditions	Ι,	D													
	D H	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Į		(or as a c	conseque	nce of):										
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	) (	Due to	(or as a c	conseque	nce of):										
760,	ate be executed hysician and he burial-transit	calE		l.	4	(												
687	ificate g phys as the				J													
ŏ	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	2	3c. If yes, ou		pregnanc		Ectopic pr	regnancy						e of delive	*	
B	e deat he att	sicis	in the past 12 months?			nant at tin	ne of deal		Other (sp						Moi	nth	Day Y	/ear
о. О	The law requires that the de ite has been signed by the r bage 2 should be detached		9 ☐ Unknown  Part II. Other significant conditi	ons cor	atributing to d	leath hut r	not resulti	ng in the u	nderlyina c	alice dive	on in Part I		23e. Did to	hacco i	use cont	ribute to th	e cause of de	eath?
ds,	signed to det	d by	Turris order organization		in butting to a	outil but	not roball	ng in the a	. Idony IIIg o	aaso giir	JII #11 T C.1. 1.						ably 4 □U	
Records,	w require been si should t	Completed											24a. Was	an	24b. \	Nere autor	sy findings a	available
Re	The lav	omo											autop	rmed?	P	orior to con leath? 	npletion of ca	use of
Vital		Be C	25. Was case referred to medica	-							26. Place	of Death	1 ☐ Yes	2 <b>X</b> No ne)	<u> </u>	165	20 140	
of <	S S D	To E	examiner? 1 ☐ Yes 2 X No	F	lospital:	Inpatient	2□EF	VOutpatier	nt 3 🗆 DC	Othe	9F: 4 □ Nu	rsing Ho	me 5 <b>⊠</b> Resid	lence	6 🗆 Oth	er (Specify	)	
	ding Ph h. After thi funeral		27. Manner of Death 1 X Natural 5 ☐ Pendir	ng	28a. Date (Mon	of Injury oth, Day Y		8b. Time of Injury		8c. Injury Work			28d. Describe h	iow in <del>j</del> ui	y occurr	ed		
Sio	Attendi death. ctor: A y the fu	icat	2 Accident Investi	gation not be	280 Blace	of Injune	At hom	o form sta	M dastas		Yes 2 1		28f. Location (S	Stroot ar	nd Alumh	er or Pura	Doute Mumi	hor
Division	or Attend after death Director: /	Certification:	4  Homicide determ	nined	build	ing, etc. (	(Specify)	e, farm, str	eet, ractory	/, office			City or Tow			er or nura:	HOULE INVITE	<i>J</i> 61,
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in In		29a. Certifier 1 Certifyin	ng Phys	sicien: To the	e best of r	my knowle	edge, deati	h occurred	at the tim	ne, date an	d place,	and due to the	cause(s)	and ma	nner as st	ated.	
	he Ho in 24 I he Fu pletely	edical	(Check only 2 Medicel one)	Exemi	ner: On the b and man	asis of ex iner state	xamination d.	n and/or in	vestigation	, in my or	oinion, deal	th occurr	ed at the time,	date and	I píace, a	and due to	the cause(s)	ſ
	To the within 2 To the complet	Σ	29b. Signature and title of certifie	71 1				A	290		number	27	1				Day, Year)	
1	/		PN- G	2	ou		jul	7		1)/	91	> 7		The same of the sa	> .	19.	01	
	15		30. Name and address of person	who co	mpleted caus	se of deal	th (Item 2	3a) (Type,	Print)	61	vd	0	1122	1				
	Sta	te	31. Date filed (Month, Day, Year,	)	\$2. F	legistrar's	s Signatur	Good	d a									
	Registr	ar	MAY 2.0 2	2005	Klas	w.	A.	GOSA										

05-3165 B.K.S

OBERT LITTL	E	1 - For State Registrar		State	or maryl		partmen <i>ertificat</i>				nental F	lygie Reg.	00	ne	I way for your
الركاريني أ		Decedent's Name	(First, Middle	e, Last)							2. Date of		- b 3, f	V	3. Time of Death
Physic /Medi		Rober	t Lloy	d Little							Month MAY	6,	2005	Year	10:05 P M
Examir		4a. Facility Name (If 5356 SIN		n, give street and nu LANE APT					r Location RE C	n of Death			4c. County	of Death	
Funeral		5. Social Security Nu	mber	6. Sex 1 ☑ M 2 ☐ F	7. Age (In )	yrs. last birtho	fay) If Under	r 1 Year		er 24 Hrs.	8. Date of (Month, Aug 2	Birth Day, Ye	ear)	Cou	place (State or Foreign
Director	Ļ	237-24-49 Usual Residence of I			٤	38 Yrs	5.		L		Aug 2	8, 1	916	Mar	yland
yland			10b. County		10c.	. City, Town o	r Location								10d. Inside City Limits
with the Maryland a or 28a-1 show	ctor	MD				Ва	ltimor	e							1 Yes 2 □ No
ith the	Olre	10e. Street and Num					10f. Zip	Code				10g.	. Citizen of \	What Cou	ntry?
ath with s 23a or ust be	ral	5356 Sin	clair :					212					US		
-0036 hours after death tural; or frems 23	by Funeral Director	11. Marital Status 1 ☐ Never Marrie 3 🕅 Widowed		If Ves G	orces? 2 □ No ve	in U.S.	13. Was Deced If Yes, sped 1 ☐ Yes		ispanic C an, Mexic Specify		ecify Yes or Rican, etc.)	No-		ck, White,	can Indian, etc. Dlack
2 hou	ted		15. Decedent	t's Education		16a. De	ecedent's Usu	al Occupi	ation			168	b. Kind of B	usiness/Ir	ndustry
1215- within 72 ene. than "nat	Completed	Elementary/Secon		st grade completed) College (	1-4or 5+)	— (G	Rive kind of wo fe. DO NOT u	rk done d se retired	during mo 1)	ost of work	aing				•
d 21; filed with Hygiene other the	Con	12		0			steel	work					beth1		steel
E B E P ≥	Be	17. Father's Name (F		•							e (First, Midd Cradd			ne)	
should nd Men marke	P	19a. Informant's Nar	me/Relations	hip (Type, Print)		19b. M	lailing Address	(Street						State, Zij	o Code)
	П			le/daught	er		04 Dail							7577	
altimore, mit. Pages 1 ar partment of Hea portant: If item: y injury or other ce.		20a. Method of Dispo 1 ☐ Burial 2 ☐ 1 4 X Donation	Cremation	3 □Removal from	State 20	b. Place of Dicemetery,	isposition (Nar crematory or c	me of other plac	ce)	l	Date	200	c. Location -	City or T	own, State
Baltimor permit. Pages Department of P Important: If ite any injury or of once.		21. Signature of Euro	eral Serve	Licensee S. Wade,	Direct		State . Baltim	Anat Anat	omy MD	Board 2120	655 T	<b>V.</b> В	altim	ore :	Street
		23a. Part 1 Enter the	e disease, or	complications that	ceused the deach line.					as cardiac	or respirator	y arrest,			Approximate Interval Between
Pnysician		Immediate Cause (F	inal	<u>,</u>	4	uxia									Onset and Death
/Medical		resulting in death)		Due to	_	s uence of):									
Examiner	la.	Sequentially list con-	ditions,	b	/										
ped the transfer	nlner	Sequentially list con- if any, leading to imr- cause. Enter Underl Cause (Disease or in	mediate lying niury	Due to	(or as a con	sequence of):									
execu	Examin	that initiated events resulting in death) La		c. Due to	(or as a con	sequence of):									
8760, cate be executed obysician and the burial-transit	dical			d											
	- Φ	IF SENANT.													
Vision of Vital Records, P.O. Box 6: Attending Physician: The law requires that the death certificate has been signed by the attending petor: Atten this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 n 1 □ Yes 2 □ 9 □ Unknown	nonths?		birth 2 ☐ F nant at time	Fetal death	3 □Ectopic pr 5 □ Other (sp		1				23d. Dat Mo	te of deliv	ery Day Year
, P.O. that the de ned by the a	Ph	Part II. Other signific	cant condition	ons contributing to d	leath but not	resulting in th	e underlying c	ause give	en in Part	t I.	23e. Di	d tobac	co use cont	ribute to t	he cause of death?
Division of Vital Records, P.O. or Attending Physician: The law requires that the darker death.  Incorporate this certificate has been signed by the lin by the funeral director, page 2 should be detached.	ed by					3	,	- g-/				☐ Yes	2 No	3 🗆 Prot	
as beer 2 shou	Completed										24a. W		24b. \	Were auto	ppsy findings available
I Re( The lav	mo										au pe 1∭ Yes	itopsy orformed s 2 🗆	1?   0	death?	mpletion of cause of 2□ No
Vital F Ician: Th certificate	Be C	25. Was case referre	ed to medical						26. Plac	ce of Deat	h (Check on			<b>A</b> 100	2010
of Vita Physician: this certific	P	examiner?	10			2 ER/Outpa		- A	4 🗆 N		me 5 Re				M AT SCENE
On O		27. Manner of Death 1 □Natural	5 Pendin		ith, Day Year	r) 28b. Tim Inju	e of 2	8c. Injury Work	vat k?		28d. Describ	b.	injury occurr		d
ision vitending death.	icat	2 Accident 3 Suicide	investig 6 ☐ Could r	not be		At home form	OUSPM	1 🗀 '	Yes 2L	No	Subject		. 0	digital	al Route Number,
Divisic al or Attence after death i Director: d in by the	Certification;	4 Homicide	determ	ined 289. Flact build	ing, etc. (Sp	ecify)	street, factory	, опісе			City or	Town, S			sin clair Lan
DIVIS  To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	Medical C	29a. Certifier (Check only one)	Certifyin	g Physician: To the Examiner: On the b and man	a best of my pasis of examiner stated.	knowledge, d	eath occurred	at the tim	ne, date a pinion, de	and place, eath occuri	and due to the	he caus le, date	e(s) and ma and place, a	nner as s	tated. the cause(s)
To the within 2 To the complete	Me	29b. Signature and t	itle of certifier	r			290		number	г			Date signed		
		> hing	hi	, mis				OC	ME			M	IAY 7	, 200	כו
_		30. Name and addre	ss of person	who completed cau	se of death (	(Item 23a) (Ty								D-8/16	
		21146					111	Penn	Str	eet	Balti	nore	e, Mar	ylan	d 21201
Sta Regista		31. Date filed (Month	AY 2 0	2005	Registrar's Si	ignature	bester								

			1 - For State Registrar		aryland / Depa		Health a	nd Mental Hygi	_	17059
	Physici /Medic		1. Decedent's Name (First, Middle, La	C.		Mer	ritt	2. Date of Death Month May	Day Year 7 2005	3. Time of Death 7:45a. M
	Examin		4a. Facility Name (If not institution, gir Stella Maris 1	owson		To	, or Location of		4c. County of Death Baltimo	re
	Funeral Director			Sex 7. Ag 1 □ M 2 🌠 F	ge (In yrs. last birthday)  88 Yrs.	If Under 1 Yes Months Day		4 Hrs. 8. Date of Birth (Month, Day, 03 06		place (State or Foreign intry) MD
	e Maryland Be-f show	ctor	10a. State 10b. County  MD NA		10c. City, Town or Lo	nore				10d. Inside City Limits  Y☐ Yes 2☐ No
-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. It marked other then "neturel", or Items 23e or 28e-f show other treumetic event, the Medical Exandration in the Colline 1 at	ed by Funeral Director	10e. Street and Number  717 Druid Par  11. Marital Status  1 Never Married 2 Married  Widowed 4 Divorced  15. Decedent's E	12. Was Decedent Armed Forces' 1 ☐ Yes 2.F3 If Yes, Give Year or Dates:	No 16a Dece	Was Decedent of If Yes, specify Control of Yes 2 X N	21217  If Hispanic Origuban, Mexican,  No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	U • S • A  14. Race - Amer Black, White  Specify:  B  16b. Kind of Business/	ican Indian, , etc.
21215-0036	within 72 iene. then "ne the Medic	Completed	(Specify only highest gi Elementary/Secondary (0-12) 12th grade	College (1-4or	(Give 5+)	kind of work don DO NOT use ret	ne during most ired)	of working	Private	
	should be filed tod Mental Hygis s marked other umetic event, I	To Be C	17. Father's Name (First, Middle, Las	")	bai	JY SILI	18. Mother	's Name (First, Middle, N Bell Hebb	faiden Sumame)	
Σ	nd 2 shou alth and M 27 Is mar r treumet		19a. Informant's Name/Relationship  Philip Lee-Bro	(Type, Print)			et and Number	or Rural Route Number,	City or Town, State, Z.	
imore	t. Page rtment c rtent: If rjury or		20a. Method of Disposition  XXBurial 2 ☐ Cremation 3 [     4 ☐ Donation 5 ☐ Other (Spec	□Removal from State fy)	20b. Place of Dispo cemetery, crea	sition (Name of natory or other p	olace)	Date 2	Baltimor	Town, State
	Physician		23a. Parri. Enter the disease, or cor shock, or heart failure. List only mmediate Cause (Final		d the death. Do not entine.	4300 Wa	abash	Ave, Balti	imore, Md	21215 Approximate Interval Between Onset and Death
	Medical Examiner buysician and bhysician and sthe burial-transit	cal Examiner	dispesse or condition leculting in death)  Sequentially list conditions, if any, leading to him order cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	b. Dine to (or as	s a consequence of): s a consequence of):					
	The law requires that the death certificat te has been signed by the attending phyage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown		2 Fetal death 3	]Ectopic pregnal ] Other (specify)			23d. Date of deliv	very Day Year
rds, P.	quires that n signed by ald be deta	by	Part II. Other significant conditions	contributing to death	but not resulting in the u	nderlying cause	given in Part I.		acco use contribute to	-
		Completed						24a. Was ar autopsy perform 1 Yes 2	prior to c ned? death?	opsy findings available ompletion of cause of
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital:	ient 2 ☐ ER/Outpatie	3 T DOA	Othor	of Death (Check only one	to a	HOCDICE
	ling P	ation: To	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da	ury 28b. Time o	1 28c. In	njury at Vork?	28d. Describe ho		ity) HOSPICE
	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could not 4 Homicide determine	28e. Place of In	jury - At home, farm, st tc. (Specify)	eet, factory, offic	ce	28f. Location (Str. City or Town	eet and Number or Rui , State)	ral Route Number,
	To the Hospitel or Att within 24 hours after d To the Funerel Direct completely filled in by	Medical	29a. Certifier Check only one) Certifying Condition 2 Medical Example 1	hysician: To the best miner: On the basis and manner s	of examination and/or in	vestigation, in m	y opinion, death	place, and due to the ca h occurred at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
)	To t To t	×	29b. Signature and title of certifier	10-			ense number		3d. Date signed (Month) $\frac{5}{17}$	
	7		30. Name and address of person who		death (Item 23a) (Type,	Print)		TUM, MD 210	90 10	
143 143 143 143 143 143 143 143 143 143	Sta Regist		31. Date filed (Month, Day, Year) MAY 2 0 2	32 ABenist	rar's Signature		1111011	210	<i>2.</i> <b>3</b>	

7:45 a.m.

MAY 17, 2005

FRANCES MERRITT

			For State Registrar	State of M	laryland / i		artment of I rtificate of		nd Mental H	ygiene Reg. No.	2005	17060
	n		1. Decedent's Name (First, Middle,	Last)					2. Date of I	Death Day	Voor	3. Time of Death
	Physici /Medic		TRUDY M.	MATTH	ews				05	//7	/ 2005	1=15AM
	Examin		4a. Facility Name (If not institution,	give street and number	7)		4b. City, Town,	or Location of E	Death	4c. (	County of Death	
				Malil Madril			BAL		re		N/A	
	Funeral			5. Sex 7. A 1 M 2√2 F	ge (Kh yrs. last bi		If Under 1 Year Months Days			Birth Day, Year)	9. Birthp	ace (State or Foreign try)
	Director		218-52-3641 Usuel Residence of Decedent	-X-	83	Yrs.			12 2	24 19	21 (	A
	land 1		10a. State 10b. County		10c. City, Tow	m or Lo	ocation				1	Od. Inside City Limits
	Mary	ō	MD N	/A	Bal	time	ore					1 X Yes 2 ☐ No
	r 28a	Director	10e. Street and Number	,		C	10f. Zip Code			10g. Citiz	en of What Coun	try?
	h with		1818 E. 31st	Street			21210	)			USA	
	deati	Funerai	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	13.	Was Decedent of I	Hispanic Origin	? (Specify Yes or N		4. Race - Americ	
ထွ	after or Ita	F	1 Never Married 2 Marrie				If Yes, specify Cub 1 ☐ Yes 2 ☑ No		ruento Hican, etc.)		Black, White,	etc.
g	ural',	d by	<b>≯</b> Widowed 4 ☐ Divorced	Year or Dates:	:			орвину.			Specify: Bla	ck
21215-0036	be filed within 72 hours after death with the Maryland hat Hygiene. Id other than "naturel", or Itams 23e or 28e-f show event, I've Medical Examire transite notified at	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a	(Give	dent's Usual Occup kind of work done	during most of	working	16b. Kin	d of Business/Ind	lustry
12	withir ana. than	m du	Elementary/Secondary (0-12)	College (1-4or			DO NOT use retire	ia)				
2	filed Hygie other		7th 17. Father's Name (First, Middle, Li	N/A		Hous	sewife	18. Mother's	Name (First, Midd		ome Sumame)	
an	d be antal ced o	o Be	John Henry	Jackson					lter		,	
Maryland	ges 1 and 2 should be filed it of Health and Mental Hygi If itam 27 Is marked other or othar traumatic event, II	은	19a. Informant's Name/Relationshi		198	o. Mailir	ng Address (Street		r Rural Route Num	Dav:		Code)
	2 5 5 G		Lorraine Lane-d	aughter			Ivanhoe					
ē,	itam itam		20a. Method of Disposition		comoto	f Dispo	sition (Name of natory or other pla	ce)	Date		ation - City or To	wn, State
Ē	Page nent contract int: If		1 🔀 Burial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Spe	_	a		ville VA	, I	/23/2005	Cro	wnsville	MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 eny injury or other once.		21. Signature of Funeral Service Li	censee		22	2. Name and Addre	ess of Facility	MARCH FU	NERAL	HOME-EA	ST
_	40 F P 9		Aladi	y Wo	me_		1101 E. N	lorth Av	venue Ba	ltimo	ce, MD	21202
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that cause nly one cause on each	ed the death. Do line.	not ent	er the mode of dyi	ng, such as car	rdiac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a.	INTRA	Ver	tricular	hen.	whele			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence	of):						
		_	Sequentially list conditions,	b. Thun to Joka	s a sonsequence	-n						
ī	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury		a a consequence	<b>υ17</b> .						
	axecu and al-tra	xar	that initiated events resulting in death) Last	c. Due to (or as	s a consequence	of):						
8760,	death certificate be executed e attending physicien and id for use as the burial-transit	dicai E		d								
.89	ificati g phy as the	edic										
Вох	leath certific attending p	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		٥٦	7e			23	3d. Date of delive	у
ω.	ne deati the atte	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant a	2 Fetal death at time of death		Ectopic pregnanc Other (specify) _	у			Month	Day Year
P.0	<b>⇒</b> > ○	hys	9 🗆 Unknown	9□ Unknown								
	89 69	by Physician/Me	Part II. Other significant condition	s contributing to death	but not resulting i	n the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco us		e cause of death?
bg	w require	ted							1	Yes 2	No 3 ☐ Proba	ıbly 4 ⊡Unknown
Records,	e faw i has b	Completed							24a. Wa	opsv	24b. Were autop	sy findings available
H		Cou							per 1 ☐ Yes	formed? 2 D No	death? 1 ☐ Yes	2□ No
Vital	yalclan: The is certificete director, pag	Be	25. Was case referred to medical examiner?	Hospital:			0#		Death (Check only	one)		
ot	X X	. To	1 ZYes 2 No 27. Manner of Death	28a. Date of Inj		itpatien Time of	JUDON		ng Home 5 ☐ Res 28d. Describe			)
Division of	Attanding Phyaiclan: r death. actor: After this certific by the funeral director.	tion	1 ☑Natural 5 ☐ Pending	(Month, Da	ay Year)	njury	Wo	rk? Yes 2 □ No	Zod. Describe	now injury	occurred	
18	I or Attandi after death I Diractor: A d in by the fu	fica	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place of In	ijury - At home, fa	ırm, str	eet, factory, office		28f. Location	(Street and	Number or Rural	Route Number.
5	in the	Certification:	4 Homicide	building, e	tc. (Specify)		,,,		City or To	own, State)		,
	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best caminer: On the basis of and manner s	of examination an	e, death	occurred at the tile restigation, in my o	me, date and popinion, death of	lace, and due to the	e cause(s) a , date and p	and manner as sta place, and due to	ited. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licens	se number	-	29d. Date	signed (Month, L	Pay, Year)
}			> 20em				MA	11 17	age -	05/	12/20	
	6		30. Name and address of person wi	no completed cause of	death (Item 23a)	(Туре,	Print)		10)	1	. // / 00.	
	9		Chock		22500	#	Greave	Stree	A BACA	7000	ND, 2	1201
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 0 2	2005 Alexander	rar's Signature	Gas	معالم		985 A BAN			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** 405AM Manley Doretha Ma 3 2005 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Manyland medical Center Baltimore MIA If Under 1 Year If Under 24 Hrs.

Months Days Hours 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 XF Director Vorsh with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or itams 23a or 28a-f shov traumatic event, the Medical Exeminar must be notified at 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Cod 10g. Citizen of What Country? Funerai Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 2 Married □Yes 2XNo Yes, Give 1 Never Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens important: if item 27 is marked other that any july or other traumatic event, the Once. Eather's Name (First, Middle 18. Mother's Name (First, Middle, Maiden Sumame) Jer 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, 622 Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory of other p Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEDSIS /Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician P.O. Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has page 2 s autopsy performed certificate 2Q No 1 Yes or Attanding Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Naturat 2 Accident 5 Pendina death. investigation 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide after Hospital filled within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

21 3. Greene St

MD

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jones

Abbu

MAY 2 0 2005

31. Date filed (Month, Day, Year)

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Baltmine MP ZIZOI

13 2005

			1 - For State Registrar	State of M	laryland / D		t of H			al Hygie	•	05	17062
	Physici	an	1. Decedent's Name (First, Middle, L							te of Death	Day	Year	3. Time of Death
	Physici /Medic			ardiner	Monta				Ma			005	4:03 P <sup>M</sup>
	Examin	er	4a. Fecility Name (If not institution, g				_	Location of C	Death		4c. County		
			Carriage Hill No. 5. Social Security Number 6.		ue ge (In yrs. last birth		Bethe	esaa If Under 24	Hrs. 8 Dat	e of Birth		tgome	
	Funeral Director		411-58-2997	1□M 2□XF		rs. Months	Days	Hours I	Min. Ma	e of Birth onth, Day, Y	(ear) L913		lace (State or Foreign htry) ginia
	p.		Usual Residence of Decedent		T								
	arylar show	_	Maryland Mont g	omary	10c. City, Town		Bethe	onda				1	0d. Inside City Limits 1X Yes 2 □ No
	the M 28a-f	ecto	10e. Street and Number	Oner y		10f. Zip				100	Chinan of	Mhan	
	23e or 3	Funeral Director	5215 Cedar Lan	e		Tor. Zip		20814		109	Unit	ed St	-
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, its Madical Exerciting must be notified at once.	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1  Yes 2  If Yes, Give Year or Dates	? [No	13. Was Deced If Yes, spec	**	spanic Origin n, Mexican, P Specify:	? (Specify Ye uerto Rican,	etc.)		ce - Americ ck, White, y: Wh	
21215-0036	72 hou	Completed	15. Decedent's	Education	16a. [	Decedent's Usua	al Occupa	ation	warking	16	b. Kind of B	usiness/ln	dustry
21	ithin 7 le.	nple	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or	5+)	(Give kind of woillife. DO NOT us			_				
2	ygien ygien her th			5+	En	glish Te	each						vernment
anc	ntal Hed of	Ве	17. Father's Name (First, Middle, Las		Warren			Le1:	Name (First,		Reyno1	,	
Maryland	d 2 should th and Me 7 is mark traumation	To	19a. Informant's Name/Relationship Patricia T. Mon	(Type, Print) Da	mohter 19b.	Mailing Address 804 36t1	(Street a	and Number o	r Rural Route	Number, C	ity or Town,		
re,	item 2		20a. Method of Disposition		20b. Place of l	Disposition (Nan	ne of	7	Date		c. Location -	City or To	wn, State
imo	Page ment c ant: If ury or		1 ☐ Burial 2 🔯 Cremation 3 1 ☐ Donation 5 ☐ Other (Spec		9	eake Cr			5/17/05	5	Be1t	svill	e, MD
Baltimore,	permit. Departi Import any inj once.		21. Signature of Funeral Service Lic	enson Himiam	M00382			s of Facility ral and Ave., S					910
П	ь.		23a. Part1. Enter the disease, or co- shock, or heart failure. List on	nplications that cause	ed the death. Do no								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_	eumonia								Onset and Death
	/Medical Examiner		resulting in death)		s a consequence of								
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ယ္	ificate g phys as the			0.							10		
P.O. Box	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within E4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown		e of pregnancy 2  Fetel death at time of death	3 □Ectopic pri 5 □ Other (spi					23d. Dai	te of delive nth	ry Day Year
σ.	res that the designed by the a	y Ph	Part II. Other significant conditions	contributing to death	but not resulting in	the underlying ca	ause give	n in Part I.	23	e. Did tobac	co use cont	ribute to th	e cause of death?
rds	w requires been sign should be	ed by	Alzheimer'	s Disease,	Dyspha	gia,				1 🗆 Yes	2 <b>XX</b> No	3 ☐ Pr <i>o</i> ba	ably 4 □Unknown
eco	faw re as bee 2 sho	Completed	Clostridiu	m Diffcile	Colitis				24:	a. Was an autopsy	24b. \	Were autor	osy findings available
m m	The ate ha	Com							1 🗆	performe	d? (	death?	2 No
/ita	cian: ertific actor,	Be	25. Was case referred to medical examiner?						Death (Checi	k only one)			
of o	Physic this c	J.	1 Yes 2 No		ient 2 ER/Outp			4X Nursin	g Home 5				)
uc.	Jing F	tlon:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigati	28a. Date of Inj (Month, D	ay Year) 28b. Tii	me of 2	8c. Injury Work	at ? ′es 2 ∐ No	28d. De	scribe how	injury occurr	ed De	
Division of Vital Records,	l or Attendater deatl Director; I in by the	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	28e. Place of Is	njury - At home, farr				28f. Loc City	ation (Stree or Town, S	at and Numb State)	er or Rura	Route Number,
Ω	To the Hospitel or Attending Physician: The law within Ed horus after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1  Certifying F	hysicien: To the bes	t of my knowledge,	death occurred	at the tim	e, date and p	ace, and due	to the caus	se(s) and ma	inner as sta	ated.
	the H in 24 the Fi	ledical	one)	miner: On the basis and manner s	tated.				ccurred at the				
	To To	Σ	29b. Signature and kitle of certifier	7 / ·	-	29c	License .	number 35579		29d.	Date signed	16, 2	
			30. Name and address of person who	completed cause of	death (Item 23a) /T	vne Print)		,,,,,			11cl y	-0, 2	
	2		Susan J. Mille				errac	ce, Bet	hesda	, MD	20816		
	* Sta	te											
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State of Maryland / Department of Health and Mental Hygiene) 1- State RegistamEND ITEM #9 PER FH G843 5/249 Tifigate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav **Physician** Martin-Butler Dorothy Louise 1:17 A May 16. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Montgomery Rockville 8. Date of Birth (Month, Day, Year) 1111y I, 1917 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Countily) **Funeral** Months Days Hours Min. 1 ☐ M 2√2 F 261-30-5990 87 Yrs. Director FLORIDA Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a State 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Modical Examinations as the modified at 1 XYes 2 ☐ No Rockville Director Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 United States 6105 Montrose Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ (MNo If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black <u>م</u> 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 permi: Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bethe1 Florie Bethe1 Arthur 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Ashmont Ct., Silver Spring, MD Eugene Martin / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Crematory 05/17/05 Beltsville, MD <sup>1</sup> 4 □ Donation 
<sup>2</sup> □ Other (Specify) NO0382 22. Name and Address of Facility Rapp Funeral and Cremation Services 23a. Part1. Enfer the disease, or complications that cau shock, or heart failure. List only one cause on eac 933 Gist Ave., Silver Spring, MD 20910 Approximate Interval 8 etween Onset and Death r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, t only one cause on each line. Immediate Cause (Final **Physician** Disorder Seizure disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Pricemonia Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner use as the burial-transit Cerebellar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Box 68760 certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Tes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No certificate has autopsy 1 Yes 2€ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 1 Anpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending P. 24 hours after death. e Funeral Director: After t Certification: After 1 ANatural 5 Pending investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0061307 May 16, 2005 30. Name and addr. s of person who completed cause of death (Item 23a) (Type, Print) Atul Rohatgi M.D.; 9901 Medical Center Dr., Rockville, MD 20850 31. Date filed (Month, Day, Year) State Registrar MAY 2 0 2005 DHMH 17 Rev 1/2001

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			1 - For Stata Registrar	State of M	aryland	/ Depa	artment o	of Health of Death	and M		jiene () ag. No.	05	17064
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	Examir	ier	4a. Facility Name (If not institution, g					m, or Location	of Death			ty of Death	
			Howard County G			A 6 2 4 1 1	Colum If Under 1 Y		e O.4 Lien		Howar	-	
	Funeral Director		5. Social Security Number 6. 212-36-2680	Sex 7. Ag 1√2 M 2□ F	je (In yrs. las 65	Yrs.		ear If Under ays Hours	Min.	8. Date of Birth (Month, Day) JULY 9,	Year)	Cou	place (State or Foreign ntry)
			Usual Residence of Decedent	21						OULI JI		wes	t Virginia
	ylanc		10a. State 10b. County			Town or Lo	cation						10d. Inside City Limits
	a-1si	tor	MD Howard		Elkr	idge							1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number				10f. Zip Cod			1	0g. Citizen of	What Cou	ntry?
	23a (	ai [	6941 Dorsey Roa	d			21	L075			USA		
	r dea	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		13. \	Was Decedent f Yes, specify (	of Hispanic Or Cuban, Mexica	rigin? (Spe	ecify Yes or No- Rican, etc.)		ce - Amen ack, White,	
36	or it	by Fu	1 ☐ Never Married 2 AMArried 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No		1 ☐ Yes 2√2	No Specify	r:			ity: whi	
0	hour tural	ed b	15. Decedent's	Year or Dates:		16a Decer	dent's Usual Oc	cupation					
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ğ	illec Hyg othe ent,	BeC	17. Father's Name (First, Middle, Las	st)				18. Moth	er's Name	(First, Middle, I			
Jar	ould be filed within 72 hours after death with the Maryland Mental Hygiene. Arked other then "natural", or items 23e or 28e-f show afte event, I'm Medical Eriar is arread be rediffed at	To B	Cecil J. McClun	g				Ethe	1 D.	McClung			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other treumetic event, it is the disciplinated any injury or other treumetic event, it is the disciplinated and once.		19a. Informant's Name/Relationship							I Route Number		n, State, Zip	o Code)
Σ,	and and a		Laura McClung -	wife 					Elkri	ldge, MD	2107	5	
altimore,	of He		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3	□Removal from State	20b. Plac	e of Dispo letery, cren	sition (Name o natory or other	f place)		Date	20c. Location	- City or To	own, State
Ĕ	Pag ment ent: i		'4 □Donation 5 □ Other (Spec		Meado	owrid	ge Mem.	Park	5/24	1/05	Elkri	dge, i	MD
Balt	ermit. epart nport ny inj		21. Signature of Fune at Service Lic	ensee		22 C-2	. Name and Ad	dress of Facil	ity Franc	aral Hom	o a Moo	downi	dge MP, Inc.
	707 e o		MAGIN			72	50 Wash	ington.	Blvc	l. Elkr	idae. I	MD = 2	1075
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Z	nysician	i N	Immediate Cause (Final disease or condition resulting in death)	a. PNEUN	AI NOS								one mak
	/Medical Examiner		resulting in dealing	Due to (or as	a consequer	nce of):							
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89	tifical ng phy as th	ledi											
Вох	eath certific attending p for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregna	ancv				ate of delive	*
Э.	e dea he att ed fo	sicla	in the past 12 months?	4☐Pregnant at 9☐Unknown			Other (specify				М	onth	Day Year
о. О	at the de	Physician/Me	9 Unknown							7	_		
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										perform 1 Yes 2	No No	death? 1 ☐ Yes	2 □ No
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ō	Phys rat di	- To	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 Inpatie		VOutpatien  Bb. Time of	I SEI DOA	4 🗀 141	-	ne 5 🗌 Reside 28d. Describe ho			y)
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Division of	Attan dea ctor y the	fica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Inju	ury - At home	e, farm, stre	eet, factory, offi	ice	2	28f. Location (Sti	eet and Num	ber or Rura	I Route Number,
5	alor A after Direc din by	Certification:	4 🗋 Homicide	building, etc	c. (Specify)					City or Town	, State)		
	ospit hour: mera y fille		29a. Certifier 1 Certifying F	Physicien: To the best	of my knowle	edge, death	occurred at th	e time, date ar	nd place, a	and due to the ca	use(s) and m	anner as si	tated.
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certificacompletely filled in by the funeral director,	Medical	(Check only 2 Medical Executions)	aminer: On the basis of and manner sta	t examination	and/or inv	estigation, in n	ny opinion, dea	ath occurre	ed at the time, da	ite and place,	and due to	the cause(s)
	Tot Com	Σ	29b. Signature and title of certifier					ense number		29	d. Date signe	ed (Month,	Day, Year)
			1 YEX	no			D	51860			MAG	19	2005
	10			o completed cause of d							7	,	
	Ψ		JONATHAN FISH		o CHA	40	DRIVE	# 200	Co	LUMBIA	mo z	1044	
(E)	Sta Registr		31. Date filed Month, Pay, Year 05	32. Registra	por for	<b>CLASS</b>							

			1 - For State Registrar	State of M	aryland	-	artmen rtificat					Reg. No.	000	5	17065
	Physici /Medio		1. Decedent's Name (First, Middle, Las Edward Earl Mars								2. Date of De Month May	Day	200	9er 05	3. Time of Death
	Examin		4a. Facility Name (If not institution, give 906 S. Beechfield					Town, or ltime	Location o	of Death			County of N/A	Death	
	Funeral Director			ex 7. Ag		ast birthday) Yrs.	If Under Months	n 1 Year Days	If Under: Hours	Min.	8. Date of Bir LO-16-1	19 28	9 M	Birthpi Coun lary	lace (State or Foreign to) Land
	yland sow		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	ocation							10	Od. Inside City Limits
	Ba-fah	ctor	MD N/A		Bal	timore									1X Yes 2 □ No
	with the	Dlre	10e. Street and Number 906 S. Beechfield	l Ave.			10f. Zip	229				10g. Citi	zen of Wha	at Coun	try?
36	s 1 and 2 should be illed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 ahow other traumatic event, If a Montal Examinating the incillist a	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ⊠Yes 2 If Yes, Give I Year or Dates:		s. 13.		dent of Hi cify Cuba	spanic Ori n, Mexican Specify:		city Yes or No Rican, etc.)		14. Race -	White,	etc.
21215-0036	within 72 hou ane. than "natura	Completed	15. Decedent's E (Specify only highest gra	ducation		16a. Dece (Give life.	dent's Usu kind of wo DO NOT u ffeur	al Occupa ork done o se retired	ation during mosi )	t of workin	99		nd of Busir		dustry
Maryland 2	should be filed within and Mental Hygiene. I marked other than umatic event, It is Marked other than a matic event.	To Be Co	17. Father's Name (First, Middle, Last, William Martin	)						er's Name Moye	(First, Middle	, Maiden	Sumame)		
	and 2 sho salth and I n 27 Is ma	·	19a. Informant's Name/Relationship ( Patricia Meyer/Da								Route Numb Baltim				Code)
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tra once.		20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3 □  ★ Donation 5 □ Other   Specific Sp		20b. PI	lace of Dispo emetery, cre Stan Cemet	osition (Nai matory or d LS Lau Le ry	me of other plac S	e)		ate 0-2005		cation - Cit timor	-	
Balti	permit. Page: Department of Important: If any injury or once.		21. Signature of Funeral Service Lide	SULMILLY	mole	121 2	2 Name ar	nd Addres	s of Facilit	Home erry	Rdf La	nsdo	wne wne M	D 2	1227
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each/i	ne. ING	Do not en		de of dyin	g, such as					J	Approximate Interval Between Onset and Death Months
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequ	uence of):									
8760,	cate be executed obysician and the burial-transit	Ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequ	uence of):							-		
.O. Box 68	death certific e attending p id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal	death 3	⊒Ectopic p ⊒ Other (sp					2	23d. Date o Month		ry Day Year
Ω.	8 5 0	by	Part II. Other significant conditions of	contributing to death t	out not resu	ulting in the u	ındərlying o	cause give	en in Part I.		23e. Did t			ite to th □ Proba	e cause of death?
I Records,	The law ate has b page 2 st	Completed									24a. Was autoj perfo 1 🗆 Yes		prio dea	r to con	osy findings available appletion of cause of
Vital	Phyaician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o				
o	ding h. After fune	tlon: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigatio	28a. Date of Inju	ıry	ER/Outpatie 28b. Time o Injury		28c. Injun Work	4 🗆 140	2	ne 5 X Resi 8d. escribe			(Specify	")
Division	or Attending after death. Director: Afte	Certification:	Z	e 28e. Place of In	jury - At ho tc. (Specify	ome, farm, st	reet, factor		-111		8f. Location ( City or To			or Rurai	l Route Number,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical C		nysicien: To the best miner: On the basis of and manner si	of examinat										
	To the within 2 To the complete	Me	29b. Signature and title of certifier	1				c. License		-,1			e signed (A		
	6		30. Name and address of person who	completed cause of	death (Item	23a) (Type,		UIL	35	4	4	14/4	7 18	3,2	21229
	9		E. W. COLE  31. Date filed (Month, Day, Year).	STAGA 32 Raniet	IES rags Signat	90	0 0	ATC	N	BA	LTIM	ORE	MI	) 6	21229
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DHMH 17 Rev 1/2001

			1 - State Amend Item 2	State of Ma 5 <b>&amp;27 perme</b>	arylan G84:	d / Depa 3 5-04	artmen rtMēat	t of H	ealth ai Death	nd Me	_	giene Reg. No.	00		1706	66
			Decedent's Name (First, Middle, Last							1	2. Date of De	ath Day	`	'ear	3. Time of D	eath
	Physicia /Medic			Dolby Man	ches	ter						1AY	17,2	2005	1:25	E M
	Examin		4a. Facility Name (If not institution, give Saint Joseph	Medical						owso				alt	imore	
	Funeral Director			C C	e (In yrs. I	Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min.	B. Date of Bir (Month, Da lanuary	5,1915	5	Mary	ace (State or int) 'Iand	Foreign
	/land		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	ocation							10	d. Inside City	Limits
	Mary B-f sh	tor	Maryland Baltimo	re		Towson	1								1 Tes 2	Σ <b>Χ</b> Χνο_
	or 28	Olre	10e. Street and Number				10f. Zip					10g. Citiz	zen of Wh	at Count	try?	
	ath w	ral	1055 West Joppa R		Constants.	6 112		1204		-2/0	it. Van as Na		USA 14. Race -	Amorica	n Indian	
980	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show amyr injury or other traumatic event, I're Mcdical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 XX If Yes, Give Year or Dates:	,		was Deced If Yes, spec		spanic Ongi n, Mexican, Specify:	Puerto R	ify Yes or No ican, etc.)			White, e		
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22	filed v Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)			ПО	шешак	.ei	18. Mother	's Name (	First, Middle			Oile		
Maryland 21215-0036	ould be Mental tarkad o	To Be	Edward		Do	lby				atie		0"	T 0		hrift	
	and 2 sh aith and 127 is m er traum		Jeffra Manchester		DTR	643	Picca	dill	y Roa	d Tol	Route Numb	Mary]	land	2120	)4	
altimore,	ges 1 and He If item		20a. Method of Disposition  1)∑XBurial 2 ☐ Cremation 3 ☐	Removal from State	C	lace of Dispo emetery, crea	matory or o	ther plac		Da			cation - C			ī
₽	t. Pag tment tant: ijury o		`4 ☐ Donation 5 ☐ Other (Specific	y)	Dula	eney Val								-	ryland Home Ind	
Bal	parmi Depar Impor any ir		21. Signature of Funeral Service Licer	110.	Ris		z. Name an	III Addres			Road Ba					•
П			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death	n. Do not ent	ter the mod	le of dying	g, such as c	ardiac or	respiratory a	rrest,			Approximate Interval Betwee Onset and De	een eath
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. MYDCA			FARCT	TON							TWO DI	
	/Medical Examiner		Tooling in soun,	Due to (or as	a consequ	uence of):										
	D H	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ	uence of):						w.	O HINE			
_	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consequ	uence of):						31.	MOLHO13			
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89	tificat ng phy as th		VE 55044 6								W	*8 P				
.O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 Fetal	death 3	⊒Ectopic pr ⊒ Other <i>(sp</i>			<u>-</u>	Ser. Rentlin		3d. Date of Month		y Day Ye	ar
<u> </u>	res that signed by be deta	by	Part II. Other significant conditions of LEFT FEMORAL NECK		ut not resu	ulting in the u	inderlying c	ause give	en in Part I.		23e. Did t	/			e cause of dea	
orc	w require been sign should t	eted	LEFT FERIORAL NECE	TRACTURE						_	24a. Was		T		sy findings av	
al Records,	ician: The law certificate has l rector, page 2 s	Completed									autoj perfo 1 🗌 Yes	osy ormed? 200 No	pride	or to com ath?	ppletion of cau	use of
<b>=</b>	siciar s certif	To Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	ant 2 🗆	ER/Outpatie	nt 3 🗆 DC	Othe	ar		<i>Ch</i> eck only o		Other	(Specify	)	
ı of			27. Manner of Death	28a. Date of Inju (Month, Da	ry	28b. Time o		28c. Injury Work	at at	28	d. Describe	how injury	occurred		<del></del>	
ior	auth. or: Aft	atlo	2 Accident 5 Pending investigation	May 14, 20		unknow	un™		Yes 2 XN		abject fe					
Division of Vital	al or Attence after death I Director:	Certification:	3 Suicide 6 Could not b 4 Homicide determined	building, et	ury - At ho c. <i>(Specif</i> )	ome, farm, st	reet, factory	y, office			City or To	wn, State)	201_	or Rural	Route Numbe	e <i>r</i> ,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate h, completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis of and manner sta	of my kno f examina	wledge, deat tion and/or in	th occurred ivestigation	at the tim	ne, date and pinion, death	place, ar occurred	nd due to the	cause(s) date and	and mann	er as sta d due to	ited. the cause(s)	
	To th within To th compl	Me	29b. Signature and title of certifier				290	c. License	number			29d. Date	signed (	2		
}	1		Daw D.	, well w.	4.2			D 3	6663				0	5/17	2005	
	P		30. Name and address of person who	completed cause of d	leath (Item	1 23a) (Type,								m. (-		
	Sta	ite :	31. Date filed (Month, Day, Year)	32. Registr		ture		RIV	E TOL	HOS!	MARY	LANI	21	224		
3	Registr	ar	MAY 2 0 2005	Marie	B.	Good	U									

DHMH 17 Rev 1/2001

			For Stata Registrar		State	of Maryla		artmen <i>rtificat</i>				lental Hy	/gien Reg. N	2005	71	167
	Dhysisi		1. Decedent's Nam	e (First, Middle,								2. Date of D	eath	ay Year	3. Time o	
	Physici /Medic		George		Antho		Мс	Crack				May		2005		2 M
	Examir	ner	4a. Facility Name (I		NII			4b. City,	Town, or	r Location			4	c. County of Dea	ıth	
	Funeral		5. Social Security N		Lyncar		last birthday)	If Under		NO U	r 24 Hrs.	8. Date of B	irth	N/A 9. Bi	rthplace (State o	or Foreian
	Director		216-34-3		1 € M 2 □ F	68	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D Sept.	9 , Year	1936 Ma	thplace (State of ountry) ry Land	Ciolgii
	pug *		Usual Residence of	f Decedent 10b. County		10c. C	ity, Town or Lo	ocation							10d. Inside C	ity Limits
	Manylis f sho	JO.	Maryland	Baltimo	ore		atonsv									2 No
	r 28e	Funeral Director	10e. Street and Nu					10f. Zip	Code		-		10g. C	itizen of What C		
	th with	al D	801 Win	ters Lar	ne, Apt.	#436			212	28			11	SA		
	tems	uner	11. Marital Status		12. Was Dec	edent Ever in U proes?	J.S. 13.	Was Deced	dent of H	lispanic Or an, Mexica	rigin? (Spe n, Puerto	cify Yes or N Rican, etc.)	0-	14. Race - Am Black, Wh		
36	rs afte	by Fi	1 Never Marr 3 Widowed	ied 2  Married 4	1 □Yes If Yes, Gi Year or D	ve		1 🗆 Yes						Specify: Wh		
9	2 hou			15. Decedent's	Education		16a. Dece	dent's Usua	al Occup	ation			16b. I	Kind of Business		
215	thin 7 en "n	Completed	Elementary/Seco		grade completed) College (		1	kind of wo DO NOT us	rk done d se retired	during mos d)	st of worki	ng				
2	led wi lygien her th				41		Rigg	ger		10.11.1		· · · · · · · · · · · · · · · · · · ·		aryland	Drydoc	ĸ
Maryland 21215-0036	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It and Mental Hygiene ?? Is marked other then "neturel", or Items 23a or 28e-f show treumstic event, I'm Medical Evanting must be notified at	Be c	17. Father's Name	(FIFST, MIDDIE, LA	ist)	W	. 0 . 1-					(First, Middle	, Maide			
Ž	should nd Me mark mark	2	George  19a. Informant's Na	ame/Relationship	o (Type, Print)	M	cCracke		(Street	Ann and Numb		l Route Numb	oer, City	Wojtas or Town, State,	Zip Code)	
	and 2: ealth ai n 27 Is		Geroge K	ellar	(Nepher	<b>v</b> )						ington				
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 Is any injury or other treu once.		20a. Method of Disc		☐Removal from	20b.	Place of Dispo	osition (Nari	ne of ther plac	ce)		ate		ocation - City o	Town, State	
<u>ă</u>	Pag ment tent; I			5 Other (Spe		Ba	1timore	Fari	nato	ry	May	19, 200	)5 B	altimor	Mary	Land
3alt	permit. Departr Importe any inji		21. Signature of Fu	ineral Service Lic	ensee		2:	2. Name an			, Tr(			Funera:		
	ED 2 4 0		23a, Parti enter t	he disease or or	omplications that	raused the dea	uth. Do not en							re, MD	21229 Approximat	
			Shock, or hea Immediate Cause	irt failure. List or	nly one cause on	each line.		)	o or dyar	g, such as	cardiac o	i respiratory a	a1103t,		Interval Bet Onset and I	ween
	Pnysician /Medical		disease or condition resulting in death)	on a	a. Due to	(or as a conse	U Yeu	uru							18 h	<u> </u>
	Examiner		Convention the line on	n diainna	. Ow	whele	nina.	SLASI	Z						2 day	UC
	ם יוֹ	iner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	nmediate erlying	Due to	(or as a conse	quence of).	7							.11	13
V	ecute and I-trans	Examiner	Cause (Disease or that initiated events resulting in death)	6	c. Due to	(or as a conse	quence of:								4 day	S
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit					(0) 43 4 00/139	querice or).									
687	ificate g phys	Physician/Medical			d.											
Box 6	eath certific attending p	In/M	IF FEMALE: 23b. Was deceden		23c. If yes, ou	tcome of pregr		⊒Ectopic pr	000000					23d. Date of de	livery	
В.	e deat he atte	sicia	in the past 12	□No		nant at time of		Other (sp						Month	Day 1	Year
20.	that the de ned by the a detached t	Phy	9 Unknown				. 145 - 15 - 16					00- 014				
eord ords, 4	signe d be d	d by	Part II. Other signif	CHF. A		datu pat uot ie	suling in the u	nderlying c	ause give	en in Parti	I.		1	use contribute t	robably 4 □t	
Gec	w requir been si should	lete		<del>-,) ·</del>								24a. Was		1		
Re	The lay cate has page 2	Completed by				***		·				auto perfe	psy ormed?	prior to death?	utopsy findings : completion of ci	ause of
Cen, (rital Re		Φ	25. Was case refer	red to medical						26. Place	e of Death	1 ☐ Yes	2Z No	1 ☐ Yes	2 No	
	S S S	To B	examiner?	No	Hospital: 1	npatient 2	ER/Outpatier	nt 3 🗆 DO	A Othe	-				6 □Other (Spe	cify)	
rack on of V			27. Manner of eat	h 5 🗌 Pending	28a. Cate (Mon	of Injury th, Day Year)	28b. Time o Injury		8c. Injury Work			8d. Describe	how inju	rry occurred		
	death death ctor: A y the fa	icat	2 Accident 3 Suicide	investigat 6 ☐ Could not	t be 200 Bloom	of Injury - At h	ome farm et	M		Yes 2		9f Location	Straat a	nd Number or R	ural Bouta Num	bar
N/C	after a Direc	Certification:	4 🗍 Homicide	determine	build	ing, etc. (Speci	ify)	eet, lactory	, onice			City or To	wn, Stat	9)	urai moute ivuiri	Der,
	e Hospitel or Attending 24 hours after death. e Funerel Director: After letely filled in by the fune		29a. Certifier	12 Certifying	Physician: To the	best of my kn	owledge, deat	h occurred	at the tim	ne, date ar	nd place, a	nd due to the	cause(s	and manner a	s stated.	
	To the Hosp within 24 hor To the Fune completely fi	edical	one)	2 Medical Ex	aminer: On the b	asis of examin ner stated.	ation and/or in	vestigation,	in my of	pinion, dea	ath occurre	d at the time,	date an	d place, and due	to the cause(s	)
	To the within 2 To the complet	Σ	29b. Signature and	title of certifier	į	4 4			_	e number			. /	ite signed (Mon	_	
			Vac	y MUH	phinson	n MD			170	00le			Ma	412.	2005	
	10		30. Name and addr	21	o completed caus	se of death (Ite 700 (C	т 23a) (Турв. Тъп А	Print)	Roll	Lomo	ne it	1D à	1121	19		
	Sta	te	31. Date filed (Mon	th, Day, Year)	32, F	legistrar's Sign		, , ,	uc 1	.,,,,	- 1'	,	100	۷.		
	Registr		N	1AY 2 0 2	005	we to	× Am	de								

				1 - State of Registrar	Maryland / Depa	artment of H tificate of L			ene g. No.20	05	17068
		Dhysisi	an	Decedent's Name (First, Middle, Last)				2. Date of Death Month	n Day	Year	3. Time of Death
		Physici /Medio		Joann Mitchell					2005		6:05 PM M
		Examin	er	4a. Facility Name (If not institution, give street and numb	per)	4b. City, Town, or	Location of Death		4c. County	of Death	
				Joseph Richey Hospice			timore		1		
		Funeral		5. Social Security Numberunk 6. Sex 1 ☐ M 2 ☒ F	Age (In yrs. last birthday)  59 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct 2,	Year)	9. Birthp	place (State or Foreign
		Director		Usual Residence of Decedent	37			UCL Z,	L945	Eng1	and
		/land		10a. State 10b. County	10c. City, Town or Lo	cation				1	0d. Inside City Limits
		Man a-f sh	ţō	MD	Ba1	timore					1 ☐ Yes 2√ No
		death with the Maryland ms 23a or 28a-f show Listed be rediffed at	Funeral Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of V	Vhat Cour	ntry?
		th wit	a D	139 E. North Avenue			21212		U	SA	
		ems	ner	11. Marital Status 12. Was Deced Armed Force	ent Ever in U.S. 13.	Was Decedent of Hi	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No-		e - Americ k, White,	ean Indian,
	36	within 72 hours after death with the Marylar ene. than "natural", or Items 23a or 28a-f show the Marical Examitment ast be recilied at	y Fu	1 XNever Married 2 Married 1 ☐ Yes 2	X No	1 ☐ Yes 2 🛣 No	Specify:	tion, otol,	Specify		hite
	ö	ural',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dat				11.			
	15	n 72 "nai	lete	15. Decedent's Education (Specify only highest grade completed)	(Give	tent's Usual Occupa kind of work done o DO NOT use retired	ition luring most of workii )	ng 1	6b. Kind of Bu	isiness/In	dustry
	12	withi ene. than	Completed	Elementary/Secondary (0-12) College (1-4	or 5+)	secret			temp	agen	cies
	D	Hyg other ent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, M			
	Maryland 21215-0036	12 should be filled within h and Mental Hygiene. 7 Is marked other than "! traumatic event, 12 Men	To B	Joseph Erdman			Bett	y T. Tu	11		
	ary	shot and N		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	g Address (Street a	und Number or Rura	l Route Number,	City or Town,	State, Zip	Code)
		and 2 salth a n 27 I		Michael Newman/son	373	7 Ravenwo	od Avenue	Baltimo	ore, MD	21:	213
1	ore	of He of He fiten roth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from St	20b. Place of Dispo		1		0c. Location -		wn, State
1010	altimore,	Pag ment ant: I ury o		`4□Donation 5鬨Other <i>(Specify)</i> in sta	te						
200	Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Modical Examitment at the multilled at 90ce.		21. Signature of Euneral Service Licensee Ronald S. Made D	rector St	Name and Address ate Anato Itimore,	omy Board	655 W.	Baltimo	ore S	treet
9			-	23a Part 1. Enter the disease, or complications that cal	sed the death. Do not ent				st,		Approximate Interval Between
	M	Physician		Immediate Cause (Final disease or condition	. 1	deficion	F. 1 6. 10. 1	liame-			Onset and Death
7		/Medical		resulting in death)	as a consequence of):	CARTICALON	cy syne	11011-			8 412
0	ш	Examiner		Sequencially list conditions							
9		pd ji	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence of):						
N		ecute and I-tran	Examine	that initiated events c.	as a consequence of);					-	
U	8760,	certificate be executed ding physician and tse as the burial-transit		200 10 (0)	as a consequence on,						
J.	687	icate phys s the	dic	d						-	
0	Вох (	leath certifica attending ph I for use as th	Physician/Medical		me of pregnancy				23d Dat	e of delive	erv
	ğ	that the death ed by the atter detached for u	iclaı	in the past 12 months?  1 □ Yes 2 □ No 4 □ Pregnar	nt at time of death 5 □	Ectopic pregnancy Other (specify)			Moi		Day Year
	0	t the by the ache	hys	9 Unknown 9 Unknow	n						
	S, P	res that the de signed by the a i be detached f	by P	Part II. Other significant conditions contributing to dea	th but not resulting in the ur	nderlying cause give	n in Part I.	23e. Did toba	acco use conti	ibute to th	e cause of death?
م	ırd	law requires as been sign 2 should be				<del></del>	<del></del>	1 ☐ Yes	s 2□No	3 🗌 Prob	ably 4. Unknown
Mitche	ecords,	law re as be 2 sh	Completed					24a. Was an autopsy	24b. V	Vere auto	psy findings available inpletion of cause of
1.	$\mathbf{\alpha}$	iician: The lav certificate has rector, page 2	Con					perform	ed?_	eath?	22 No
2	Vital	Physician: this certific ral director,	Be (	25. Was case referred to medical examiner?			26. Place of Death	(Check only one	)		
-	of \	Physi this c	P <sub>0</sub>	1 ☐ Yes 2 No Hospital: 1 ☐ Inp			4 - Nursing Hon			er (Specify	Hospice
5		ding F	lon	- Natural 5 - Friding	Injury 28b. Time of Day Year) Injury	Work		28d. Describe how	v injury occurr	ød	
An	isi	Attending r death. ector: Afte	Icat	2 Accident investigation 3 Suicide 6 Could not be 288 Place C	f Injury - At home, farm, str		res 2 □ No	28f. Location (Stre	eet and Numb	ar or Pum	I Pouto Number
[0	Division	for Attendater death Director: In by the	Certification:	4 Homicide determined 288. Place of building	, etc. (Specify)	ser, ractory, office		City or Town,	State)	or nura	r Houte Williber,
11		To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier (Check only   Certifying Physician: To the bas	is of examination and/or inv	occurred at the tim	e, date and place, a inion, death occurre	and due to the car	use(s) and ma	nner as st	ated. the cause(s)
		o the it in 2 o the	Med	one) and manne  29b. Signature and title of certifier	r stated.	29c. License			d. Date signed		
		± ≥ ± 8		Gtes MD		7	24171		Mari	1 7	20,0
				30. Name and address of person who completed cause	of death (Item 23a) (Type.	Print)	1.10		4091	, 4	105
		3-		E. TSO MD Richey H	ospic 838	N.Eut	awst 1	Saltimo	re M	D 2	1201
		Sta	48.0		ristrar's Signature	16.0					
	80	Registr	ar	MAY 2 0 2005 524	I Si popular	- contant					

James Massev 05-AKG

281	2		1 - For Unpend Item	State of Ma 23a,pt.II	aryland/Depa ,27 per me	artment o	f Health a -21-05 of Death	and Men tas	tal Hyg	giene	05	17069
		١.	Decedent's Name (First, Middle, L.		-			2. [	Date of Dea			3. Time of Death
	Physici /Medi		James Massey							22, 200	Year 05	12:43 P <sup>M</sup>
	Examir		4a. Facility Name (If not institution, g			4b. City, Tow	n, or Location	of Death		4c. Coun	ity of Death	
0			3631 Liberty Hei			Baltin		24 Hrs.   0.4			<del></del>	
0	Funeral Director		5. Social Security Number 6. 216-52-0174	Sex 7. Ag 1 XM 2 ☐ F	e (In yrs. last birthday) 56 Yrs.	If Under 1 Ye Months Da		Min. 8. E	Date of Birth Month, Day eb 8	Year)	Cour	
1			Usual Residence of Decedent		30			F	ED 0,	1747	Mary	land
	rylan how		10a. State 10b. County		10c. City, Town or Lo	ocation .					1	0d. Inside City Limits
	Ba-fe	Director	MD		Ba	altimore	2					1√ Yes 2 No
	death with the Maryland ms 23a or 28a-f ehow I must be rodified at		3631 Liberty He	ights Aven	ıe #A2	10f. Zip Cod	l215			10g. Citizen of	f What Cour USA	ntry?
36	after or its	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	12. Was Decedent Armed Forces? 1 ZYes 2 1 If Yes, Give Year or Dates:	No	Was Decedent If Yes, specify 0 1 ☐ Yes 2 🗓	Cuban, Mexicar	n, Puerto Rica	Yes or No- n, etc.)	Bt	ace - Americ lack, White, hify: bla	etc.
9	요 늘 글	edi	15. Decedent's	Education		dent's Usual Oc	cupation			16b. Kind of i	Business/In	dustry unk
215	- 200	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5	(Give	kind of work do DO NOT use re	ne durina mos	t of working				
21	er tha	Son	12	2	"	Carper	nter					
Maryland 21215-0036	be file tal Hy doth event	Be	17. Father's Name (First, Middle, Las					er's Name <i>(Fir</i>		Maiden Suma	ıme)	
Z	Men Men Merke Merke	1º	Melvin Mas		[			adie Mu				
Mar	12 sh h and 7 ie m treum		19a. Informant's Name/Relationship Mary Glenn/sist		1	ng Address (Str				-		Code)
	is 1 and 2 should be filed withir of Heatih and Mental Hygiene. item 27 ie marked other than other treumatic event, the Ms		20a. Method of Disposition	±1.	20b. Place of Dispo	Pentrid		Date Date		MD Z 20c. Location	.1239 1 - City or To	own. State
Baltimore,	Page nent c		1 ☐ Burial 2 ☐ Cremation 3	in stat	cemetery, crei	matory`or other	place)				J., J., T.	
Bal	permit. Departi Importi any inj		21. Sig ature of the real ervice Lice 1.00 and 1	1/1/	B	tateanAff altimor	e, MD	21201			more S	Street
8760,	/Medical Examiner prize and prize l'tausil prize l'tausil prize l'tausil prize l'autoritation de l'aut	ai Examiner	shock or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Einer Underpring Cause (Disease or injury that initiated events resulting in death) Last	a. Atherose Due to (or as b. Due to (or as c.	a consequence of):  a consequence of):  a consequence of):	ardiovas	scular	Disease	e			Interval Between Onset and Death
P.O. Box 687	death certificate e attending phys d for use as the	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at 9☐Unknown	2 Fetal death 3 time of death 5	Ectopic pregna Other (specify	)				ate of delive	ory Day Year
	w requires that the been signed by th should be detache		Part II. Other significant conditions Schizophrenia	contributing to death b	at not resulting in the u	nderlying cause	given in Part I.		23e. Did tol 1 ∐ Ye	/		e cause of death? ably 4 □Unknown
Il Records,	The law ate has b page 2 si	Completed by						[	24a. Was a autops perform	n 24b. ned? 2 \( \sqrt{No} \)	Were autor prior to cor death? 1 La Yes	psy findings available inpletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other	of Death (Ch		-/		
of	Phys this al dii	<u>٥</u>	1XXYes 2 ☐ No 27. Magner of Death	1 ☐ Inpatre		I 3 DON						at scene
uo	ding I. After fune	tion	1 Natural 5 Pending	28a. Date of Injui (Month, Day	Year) 288. Time of	٧	njuryat Work? I□Yes 2□I		Describe no	w injury occu	rrea	
Division of	l or Attending after death. Director; After in by the fune	Certification:	2 Accident Investigate 3 Suicide 6 Could not 4 Homicide determine	be Ope Blace of Inju	ury - At home, farm, str c. (Specify)			28f. L	ocation (St City or Town	reet and Num 1, State)	ber or Rura	l Route Number,
_	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying F (Check only one) 2 XMedicel Exe	hysicien: To the best of miner: On the basis of and manner sta	examination and/or in	n occurred at the vestigation, in m	e time, date an ly opinion, dea	d place, and d th occurred at	lue to the ca the time, da	ause(s) and mate and place,	ianner as st , and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	11		29c. Lice	ense number		2	9d. Date signe	ed (Month, I	Day, Year)
			1 Moujune	h. 46.10	lun	OC	ME			April	23, 2	2005
			30. Name and address of person who	completed cause of de			1 Penn	Street	Bal	timore	, Mary	71and 21201
	Sta	te	31. Date filed (Month, Day, Year)	22. Registra								
	Registr	ar	MAY 2 0 200	5 Allegras	it's Signature							

			1 - For State Registrar		State of M	aryland		irtment of H				giene	-000	7	070
			Decedent's Name (First, Middle, Last)						2. Date of Dea	ath	3. Time		of Death		
	Physici /Medi		5	amu	A ls	Jorri"	5				Month Day Year			133	O M
	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death												
			Augsbur	a L	uthera		me		arn	6411			saltin		
П	Funeral		5. Social Security Number	6. Sex	for a Colo	ge (In yrs. las 87	st birthday). Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birtl (Month, Day	, Year	l Q	thplace (State ountry)	
	Director		21 Y - 20 - 67	>4		8 /					Feb 3,1	918	VV	anylan	a
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show many injury or other traumatic event, the Medical Examinar must be routiled at ances.		10a. State 10b. Cou	•		10c. City,	Town or Lo	cation						10d. Inside	City Limits
		ģ	MD Bal	tim	ore	Ra	nda	Ustown						1 ☐ Ye	s 2 No
		Olre	10e. Street and Number					10f. Zip Code				10g. Ci	tizen of What C	ountry?	
	ath w	Funeral Director	4633 Chu	Kery				212	100				USA		
	er de	nue	11. Marital Status		12. Was Decedent Armed Forces?		13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Or In, Mexical	igin? (Spec n, Puerto F	cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whi		
36	rs aff	by F	1 ☐ Never Married 2 ☐ M 3 X Widowed 4 ☐ Divore		If Yes, Give Year or Dates:	No	1	☐ Yes 2 No	Specify:				Specify: B	lack	
5-0036	2 hou	ed	15. Dece	lent's Edu	cation			lent's Usual Occupa				16b. H	(ind of Business		
215	within 73 ene. than "n	Completed	(Specify only hig Elementary/Secondary (0-1)	College (1-4or 5+)		(Give kind of work done during most of working life. DO NOT use retired)			ng						
21	filed with Hygiene there the set, the	O.	6		0011090 (1 401	.,	T	Ruck Dr	iver			Co	unty 1	Nacnte	nance
nd	be filk tal Hy d oth	To Be (	17. Father's Name (First, Midd								(First, Middle,		Sumame)		
yla	2 should be filed withir and Mental Hygiene. Is marked other than surmatic event, the Ms		Samuel						In	ary	your	ig			
Maryland	12 sh h and 7 Is rr traur		19a. Informant's Name/Relation			1		g Address (Street a			<i>^</i>		4	,,	
	1 and 2 Health lem 27		20a. Method of Disposition	un 4		20b. Plac	e of Dispos	3 Chicken sition (Name of	1		ate   Like		ocation · City or		
Baltimore,	ages nt of t: if it		ty⊠Burial 2 ☐ Crematic		emoval from State	cen	netery, crem	natory or other plac							uland
Ħ	permit. Page Department of Important: If any injury or once.		* 4 ☐ Donation 5 ☐ Other  21. Signature of Funeral Serv		90	Gei	rrisin 22	Forest	s of Facili	N COLY 2	16,200	M	1495 1911	15, 144	young
Ba	permi Depa Impo any i			0	ayon		4	Name and Address Registed LUS W	ass	NO EN	n Fund	cra	et and	7/20	1
			23a. Part1. Enter the disease	or compli	cations that cause	d the death.	Do not ente	er the mode of dying	g, such as	cardiac or	respiratory are	rest,	20000	Approxima	ate
	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final								Onset and	Death			
4	/Medical Examiner		disease or condition resulting in death)		Due to (or as	a conseque	nce of):	1921910	(4	ivice	/			yegv	~5
			Conventially list conditions												
	₽ ≒	ner													
0	ecute and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	i											
60,	s that the death certificate be executed ted by the attending physician and detached for use as the burial-transit	E	Due to (or as a consequence of):												
68760,		dical			l										
		Physician/Me	IF FEMALE:	2	3c. If yes, outcome	of pregnance	:y						23d. Date of de	liven	
Вох		ciar	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy										Year		
P.O.		hys	1 Tyes 2 No 9 Unknown 9 Unknown												
	es tha igned l	by P							23e. Did to	id tobacco use contribute to the cause of death?					
rd	w require been sig should b								1 🗆 Y	1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown					
Records,	has has	plet									24a. Was a autops		24b. Were at	utopsy findings completion of	s available
<u> </u>		Completed									perfor	med?	death?	2 No	04400
Vital	ysician: The is certificate director, pag	Be (	25. Was case referred to medical examiner?						of Death	th (Check only one)					
of \	S S	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing H							ome 5 Residence 6 Other (Specify)					
Ē	To the Hospital or Attending Phyminin 24 hours after death. To the Funerel Director; After thi completely filled in by the funeral	in o	27. Manner of Death 1 ₩ Natural 5 □ Per		(Month, Day Year) Injury Work?					28d. Describe how injury occurred					
Division		icat	2 Accident investigation 3 Suicide 6 Could not be							28f. Location (Street and Number or Rural Route Number,					
Ď		Certification;	4 Homicide	mined	building, etc. (Specify)				City or Town, State)						
	spita nours nerel		29a. Certifier 1the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
	n 24 F n 24 F ne Fui	Medical	(Check only 2 Medic one)	al Exami	ner: On the basis of and manner st	f examination	n and/or inv	estigation, in my op	inion, dea	ith occurre	d at the time, d	late and	d place, and due	to the cause	(s)
	To the To the To the To the Comp	ž	29b. Signature and title of cert	fier				29c. License	number		2	9d. Da	te signed (Mont	h, Day, Year)	
)					X		,	V	375	13		M	94 17,	SOOS	5
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)												
	U		SEF Zibell MD 25 Main St. Reistovation MD 21136												
	Sta		31. Date filed (Month, Day, Ye		32. Registr	ar's Signatur	Θ								
	Registr	ar	MAY 2 0	ፈሀሀኃ	Molus	H	Dogw								

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryland	-	artment of H			ene . No. 2005	17071		
			Decedent's Name (First, Middle, Las				2. Date of Death Month		3. Time of Death			
	Physici		Mar	Nawro	Nawrocki			Day Year	12:00A M			
	/Medic Examin		4a. Facility Name (If not institution, give		1101111		Location of Death	May 14,	4c. County of Death			
1	LAditiii		816 Jaydee Avenu	٩		Dun	dalk		Balti	More		
	Funeral		5. Social Security Number 6. Se		last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Birth	place (State or Foreign		
	72 hours after death with the Maryland Constitute! or items 23e or 28e-f show and Exam Fact must be multihed at		215-64-8619	M 2□F 50	Yrs. Months Days Hours Min			(Month, Day, Y		<sub>intry)</sub> nnsvlvania		
			Usual Residence of Decedent					2071		misyrvania		
		Director	10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits		
			Maryland Bal	timore		D	unda1k		1 ☐ Yes 2 🔀 No			
			10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	untry?		
	h wit	a D	816 Jaydee Avenu	e			21222	T	Inited Sta	tes		
	itams 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of H f Yes, specify Cuba			14. Race - Amer	ncan Indian,		
21215-0036	urs after al', or ita	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 Tes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	Hican, etc.)	Black, White	<sub>v, etc.</sub> White		
Ö	n 72 hours "natural", edited Exa		15. Decedent's Ed		16a. Deced	dent's Usual Occupa	ation	16	b. Kind of Business/l			
15		Completed	(Specify only highest gra-	de completed)  College (1-4or 5+)	(Give life.	kind of work done o DO NOT use retired	during most of world ()	king		,		
212	filed within Hygiene. other then "ant, the wes	E o	12 Years	College (1-401 5+)	Sec	curity Gu	ard		Securi	tv		
ğ	Hyg than	0	17. Father's Name (First, Middle, Last)			arrey out		e (First, Middle, Ma.				
an	a d a b	To B	Walter Nawrock	i			There	sa Lozosk	ie			
Maryland	3395		19a, Informant's Name/Relationship (7		19b. Mailir	ng Address (Street	and Number or Ru	ral Route Number, C	te Number, City or Town, State, Zip Code)			
Ž	ith ar 1th ar 27 is 1 trau		Pastor Cameron G	lovanelli								
ā,	s 1 and 2 f Health i itam 27 i		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of			<ul> <li>Maryland</li> <li>Location - City or 1</li> </ul>			
ē	0 0		12 Burial 2 Cremation 3	Hemoval from State		natory or other plac		200E B	. 1 + i marea	Marariland		
Baltimore,	rtme rtant njury	14	' 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Fren			Cemetery		:005 B	altimore,	Maryland		
Ва	permit. Pag Department Important: I any injury o		21. Signatur of unerasserice steel	2///	Du		Funeral H		ndalk, In			
	cate be executed /Medical Examiner		23a. Part 1. Enter the disease, or comp	plications that caused the death						Approximate Interval Between		
			Onset and Death									
			disease or condition resulting in death)  a. NETA STATIC WNG CANCER  Due to (or as a consequence of):									
				b								
		ē	Sequentially list conditions, if any, leading to immediate									
p		Ë	Cause (Disease or injury that initiated events									
,		Examiner	resulting in death) Last	Due to (or as a consequ	uence of):							
68760,		dical		d								
		edic		u								
×	death certifi e attending id for use as	/W	IF FEMALE:	23c. If yes, outcome of pregnar			23d Date of delin	23d. Date of delivery				
Вох	atter for u	lar	in the past 12 months?	1 Live birth 2 Fetal	death 3	Ectopic pregnancy Other (specify)			Month Month	Day Year		
o.	0 0 0	Physiclan/M	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown  contributing to death but not resulting in the underlying cause given in Part I.								
<u>α</u>	that the		Part II. Other significant conditions or					23e. Did tobac	the cause of death?			
Š,	ding Physician: The law requires Arter this certificate has been sign funeral director, page 2 should be	d by	2						1 Yes 2 No 3 Probably 4 Unknown			
orc		etec							2010 3010			
Vital Record		To Be Completed							24b. Were autopsy findings available prior to completion of cause of			
<u> </u>						performed 1 ☐ Yes 2	7? death? No 1 ☐ Yes	death?				
ita/			25. Was case referred to medical examiner?			h (Check only one)						
of V			1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify)								
		4.00	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28c. Injury Work	28d. Describe how injury occurred						
Division		atle	Z Accident investigation	on M 1 Yes 2 No								
<u> </u>	or Attancater death Diractor: in by the	ertification	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rui	ral Route Number,		
	s after s after al Dira	Cer		J. J. J. J. J. J. J. J. J. J. J. J. J. J	,			,,-				
	To the Hospitel or within 24 hours after To the Funeral Director Completely filled in the	edical (	29a. Certifier (Check only one)	Physician: To the best of my knowledge, death occurred at the time, date and place, and due aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.					e to the cause(s) and manner as stated. ne time, date and place, and due to the cause(s)			
	o th o th ompl	Me	29b. Signature and title of certifier	tr		29c. License	number	29d.	Date signed (Month,	Day, Year)		
	r s ⊨ ō		Qoir A			D-513	555	٥	5/16/20	05		
7			20 Name and address of a second and	completed sauce of death //					1.7			
	3		30. Name and address of person who of SEIN AUVE, 910	3 FRANKLIN S	AUARE	DRIVE,	SUITE 22	OD , BALT	IMORE M	D 21237		
	Sta Registr	_	31. Date filed (Month, Day, Year) MAY 2 0 200	2. Registrar's Signat	ture 108	Les de la constante de la cons						

DHMH 17 Rev 1/2001

State Registrar

P.O. Box 68760.

Division of Vital Records.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 430 **Physician** Bertha Month Year Nelson 05 10 /Medical 05 AM 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Rock Glen Nursing Home Baltimore If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept 25, 1900 **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Hours 186-01-4231 104 Vrs Virginia Director Usual Residence of Decedent the Maryland 10a. State 10b. County item 27 is marked other than "netural", or items 23a or 28e-1 show other traumatic event, the Medical Examiner must be multified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1X7Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 10 N. Rock Glen Road 21229 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ê No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: 2 black 3 Widowed 4 □ Divorced Specify Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) domestic worker private homes permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: If item 27 Is marked othany Injury or other traumatic evant unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nellie W. Brown ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Catherine Kirk/daughter 4100 Kathland Avenue Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Ronald 5. W 22. Name and Address of Facility Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Ker 23a. Pert1. Enter the disease, or complications that caused the shock, or geart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medicai exia Due to (or as a consequence of). signed by the ettending p d be deteched for use as dementio Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 5 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? has certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No this funeral 27. Manner of Death 28c. Injury et Work? Certification: 28b. Time of within 24 hours after death.

To the Funeral Director: After completely filled in by the funer. 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only

State Registrar

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

MROWIEC

Abendeen Place 32. Registrar's Signature

Duren

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

16

29d. Date signed (Month, Day, Yeer)

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			1 - For State Registrar		State of	f Marylan	•	artment of I			lental Hy	gier Reg. 1	000		17071.
			1. Decedent's Name (First,	Middle, La	ast)			al .			2. Date of D	eath	the total total	<del>ار</del> چه	3. Time of Death
	Physic /Medi		Robert A.	Olshi	nsky						APRIL	30,	2005	Year	11:45 A <sup>M</sup>
	Exami		4a. Facility Name (If not in: 8 GLENSHAN	NON C	ve street and num	nber)		4b. City, Town, o	or Location	of Death			4c. County of		
	Funeral Director		5. Social Security Number 218-36-2426	6.	Sex 1 [X] M 2 □ F	7. Age (In yrs. I 63	ast birthday, Yrs.			r 24 Hrs. Min.	8. Date of Bi (Month, D June			9. Birthp Coun	lace (State or Foreign
	pur *		Usual Residence of Deced	ounty		10c City	, Town or L	ocation						1	0d. Inside City Limits
	Maryis f sho	ŏ	MD	Balti	more	100.0.0		sex					+	'	1 ☐ Yes 2X No
	28a	rect	10e. Street and Number					10f. Zip Code				10g. (	Citizen of Wh	nat Coun	ntry?
	h with	a D	8 Glenshann	on Co	urt #B			2.	1221					SA	•
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinat must be notified at once.	by Funeral Director	11. Marital Status 1 X Never Married 2[ 3 □ Widowed 4 □ Di		12. Was Dece Armed For 1 Tes If Yes, Giv Year or Da	2 <b>X</b> ) No e	S. 13.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No	an, Mexica	ın, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race Black, Specify:	White,	
5-0	72 ho	eted	15. De	cedent's E	ducation ade completed)			dent's Usual Occu kind of work done		st of worki	na	16b.	Kind of Busi	iness/Inc	dustry
121	vithin ne. han "	Completed	Elementary/Secondary (		College (1	-4or 5+)	life.	DO NOT use retire	nd)	0. 0. 10.	···9				
2	iled w Hygiel ther ti	ပိ	9 17. Father's Name (First, A	liddle las	0		dish	washer	19 Moth	or's Nama	(First, Middle		afood	1	
anc	d be f antal h ed ol	Be C	Anthony F.								Margar				
<u></u>	shoul nd Me mark	ပ	19a. Informant's Name/Re		<u>-</u>		19b. Maili	ng Address (Street							Code)
	alth a stranger trau		James Olshi	nsky	brother		ì	rman Hil					21222		
J.	of Hei		20a. Method of Disposition				ace of Dispe	osition (Name of matory or other pla	1		ate	_	Location - C		wn, State
Ë	Page ment ant: If ury or		1 □ Burial 2 □ Crem `4 □ Donation 5 📉			state	)	, ,	, i						
Baltimore,	permit. Departimport. any inj			d S.	wade, D	irect	/// S	2. Name and Addre tate Anat altimore,	omy I	Board 21201	655 W.	. B <i>a</i>	altimo	re S	treet
			23a. Part1. Enter the dise.	ase, or con	nplications that ca	aused the death						arrest,			Approximate Interval Between
	Physician	. 15	Immediate Cause (Final disease or condition	. cist only	Λ		MOTI	e coa	0.000	Sam	NR 1	Die.	Ast.		Onset and Death
8	/Medical	Н	resulting in death)			or as a consequ		0 044	DIOGIA		CISIO	1/0	6122.		
	Examiner		Sequentially list conditions		b										
	ed sit	Examiner	cause. Enter Underlying Cause (Disease or injury	1	Dina to (	or as a consequ	ende of).								
_	icate be executed physician and s the burial-transit	xan	that initiated events resulting in death) Last	1	c. Due to (	or as a consequ	ence of):							=	
8760,	sician buria	dicai E		l	4										
9	ifficate g phy as the	edic			u.										
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE:  23b. Was decedent pregnation the past 12 months 1 ☐ Yes 2 ☐ No			rth 2 ☐ Fetal ant at time of de	death 3	Ectopic pregnanc Other (specify)	у				23d. Date Month		r <b>y</b> Day Year
P.0	that the led by the detach	Phys	9 Unknown												
	res th ignec be d		Part II. Other significant c	onditions		ath but not resu	lting in the u	nderlying cause gr	ven in Part	I.					e cause of death?
ord	w requires to been signer should be a	eted	CARCINO	48_	OF NE	PUK_					1	Yes	2 □ No 3	Proba	ably 4 Unknown
Records,	əlaw hasb e 2 sl	Completed by									24a. Was	psy	24b. We	re autop or to con	osy findings available npletion of cause of
alF	r. The				1						1 Ves	ormed?	vo 1	TYes	2□ No
Vital	Phyaician: The law this certificate has t ral director, page 2 s	Be c	25. Was case referred to n examiner?	nedical	Hospital:			- T · Ott	30r		(Check only		Tables v	-	CONTRACTOR OF THE PARTY OF THE
Division of	<u>&gt;</u> .ײַ ס	. To	1 Yes 2 No 27. Manner of Death		28a. Date o	f Injury	ER/Outpaties 28b. Time o	IL 3 DOM	4 🗀 14		ne 5 🗆 Res 28d. Describe				SCENE
on	Attending Party death.  ector: After by the funer	tio		ending nvestigatio		h, Day Year)	Injury		rk? ]Yes 2.⊑						
Visi	Attendi er death. ector: A by the fu	Certification;	3 ☐ Suicide 6 ☐	Could not b	209. Place	of Injury - At ho	me, farm, st	reet, factory, office		2				or Rural	Route Number,
	s after s after all Director	Cert	4   Hottilde		bullair	ig, etc. (Specify	,				City or To	Wn, Sta	110)		
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Ce (Check only one)	rtifying P dicel Exa	hysicien: To the miner: On the ba and mann	sis of examinat	vledge, deat ion and/or in	h occurred at the ti vestigation, in my	me, date a	nd place, a ath occurre	and due to the	cause date a	(s) and mann nd place, and	er as sta d due to	ated. the cause(s)
	To the vithin To the somple	Me	29b. Signature and title of	certifier	λ .			29c. Licens					ate signed (		Day, Year)
)			▶ Mayri	10 l	meye	le M	P		ΜE			MAY	1, 20	)05	
			30. Name and address of p	erson who	completed cause	of death (Item	23a) (Type,	Print) 111 PFNN	ਧਵਾਣ	FT E	ξΔΙ ΤΤΜΟ	)DE	MADS/T	A NIT	, 21201
			- Hays lock	7 4.	J. ROICE	300		TTT TENTY	UIKE	L , L	NATT TIAIC	ML,	TAKI	TAINI	, 41401
	Sta Registi		31. Date filed (Month, Day,		1 2005	egistrar's Signat									
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		201					DRIGINA	Sperke							

State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month James Pannell A<sup>M</sup> 19 2005 May 6:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Joseph Richey Hospice
ocial Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 XM 2 □ F Yrs. Director 217-74-9861 43 01/16/1962 Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. Count 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Directo Maryland <u>Baltimore</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or Itams 23a 2454 McCulloh Street 21217 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Yes 2 XNo If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within lealth and Mental Hygiene 3m 27 is marked othar than Elementary/Secondary (0-12) College (1-4or 5+) Janitorial 12 Janitor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Martha Sydnor James Grady 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other trae Mary Hicks / Sister 20a. Method of Disposition 2454 McCullob Street, Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Pk. 05/23/2005 Baltimore, Maryland 21 Signature of Funeral Service Lice 22. Name and Address of Facilithe Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-transit Due to (or as a consequence of): attending physician Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) the 1 ☐ Yes 2 ☐ No څ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of desire by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed Were autopsy findings available prior to completion of cause of death?

1 Ves 2 No 24a. Was an certificate has autopsy perform 1 Yes 2 No 25. Was case reference examiner? Be medical 26. Place of Death Check only one 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: the Hospital or Attending 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No investigation 24 hours after death e Funaral Diractor; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and que to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 29b. Signature and title 29d. Date signed (Month, Day Year) 29c. License number 30. N State MAY 2 0 2005 Registrar

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Clarence Peyton 05-

		State Amend Item 1 Registrar  1. Decedent's Name (First, Middle, La								2. Date of De	ath 🦳	<del>UU5</del>	3. Time of Death
ysicia	n	Clarence Peyton	Payton			PT				May 15	, 2005	Year	5:32 P M
ledica amine	r	4a. Facility Name (If not institution, giver Franklin Square H	ve street and number)				, Town, or edale	Location	of Death			unty of Deat	e County
eral ctor		5. Social Security Number 6. 5		(In yrs. las	t birthday) Yrs.	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Mín.	8. Date of Bird (Month, Da December	th Year) 20,195	9. Birt	hplace (State or Foreign untry)
		Usual Residence of Decedent		10c. City, 1	Four or Lo	cation							10d. Inside City Limits
DE DE	2	10a. State 10b. County AL Pike			Troy	Callon							1 ☐ Yes 2 No
activative relified at	ect	10e. Street and Number				10f. Zi	p Code				10g. Citizen	of What Co	untry?
	<u> </u>	1000 Hunters Mour	ntain Parkw	ay Lo	t 303		3607	79			US	SA	
	Funeral Director	11. Marital Status	12. Was Decedent 8 Armed Forces?		13. \	Vas Dece f Yes, spe	edent of H	lispanic Or an, Mexica	igin? (Spe n, Puerto l	ecify Yes or No Rican, etc.)	- 14.	Race - Ame Black, White	
1	Dy F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1X Yes 2 □ N If Yes, Give Year or Dates:	10		1 🗆 Yes	2€ No	Specify			Sp	ecify: Bl	ack
		15. Decedent's E	ducation		16a. Deced	dent's Usi	al Occup	ation	ne of model		16b. Kind	of Business/	Industry
1	Completed	(Specify only highest gr Elementary/Secondary (0-12)	rade completed) College (1-4or 5	+)	life. l	DO NOT	use retired	during mo: d)	st of worki	ng			
		12 years	4 years		Spa	ce E	ngine		or'e Name	(First, Middle	N A S		
- 1	Re	17. Father's Name (First, Middle, Las Clarence H Paytor						Va <b>l</b> et		· .	, 1412,007, 001	mamoy	
1	0	19a. Informant's Name/Relationship		7	19b. Mailir	ng Addres	s (Street	and Numb	er or Rura	I Route Numb	er, City or To	own, State, 2	Zip Code)
		Anthony Payton	Brother		1000	Hunt	ers 1	Mount	ain I	Parkway	Lot 3	303 <b>,</b> Tr	oy AL.36079
		20a. Method of Disposition 1 → Surial 2 → Cremation 3 i	Removal from State	сеп	ce of Dispo netery, crer	natory or	other place			Date		ion - City or	
		' 4 ☐ Donation 5 ☐ Other (Spec	ify)	Fore						21,2005			
once		21. Signature of Funeral Service Lice	(. Con	nell	/ 22 C	i Name a Conne 1110	nd Addre	ss of Facil Funer ers P	al Ho	ome Of Road,	Dunda] Dunda]	lk,P.A lk, Md	21222
		23a. Part1. Enter the disease for conshock, or heert failure. List only	nplications that caused y one cause on each lir	the death.	Do not ent	er the mo	de of dyin	ng, such as	cardiac c	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as  C.  Due to (or as  d.										
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) No 9 \( \text{Ulknown} \)	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal d	leath 3	]Ectopic ] Other (s	pregnancy	y			23d	I. Date of de Month	livery Day Year
	þ	Part II. Other significant conditions	contributing to death b	ut not result	ing in the u	nderlying	cause giv	en in Part	t.				the cause of death?
	Completed					<u>-</u>				24a. Was auto perfo		prior to death?	utopsy findings available completion of cause of 2 No
	e	25. Was case referred to medical examiner?	\$1				O#		e of Death	(Check only	one)		
	0	1 No 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatie		R/Outpatier		28c. Injur	rv at	-	me 5 Resi 28d. Describe			city)
	To B	27. WILLIAM OF DOGET	28a. Date of Inju (Month, Da	y Year)	Injury	M	Woi	rk? ]Yes 2.⊑					
	To B	1 XNatural 5 Pending investigati			ne, farm, sti	reet, facto	ry, office			28f. Location ( City or To	Street and N wn, State)	lumber or R	ural Route Number,
	To B		be 28e. Place of Inj	ury - At nom c. <i>(Specity)</i>									
	Certification: To B	2 Accident investigati 3 Suicide 6 Could not determine	be 28e. Place of Inj	of my know	ledge, deat	h occurre vestigation	d at the tie	me, date a opinion, de	nd place, ath occurr	and due to the red at the time,	cause(s) an	nd manner as ace, and due	s stated. to the cause(s)
	To B	2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only 2 Medical Ex.	28e. Place of Inibuilding, et building. et building. et building. et building. et building. Et building. Et building.	of my know	ledge, deat	vestigatio	on, in my o	me, date a opinion, de se number	nd place, ath occurr	red at the time,	date and place and place 29d. Date s	ace, and due	to the cause(s)  th, Day, Year)
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led in by the funeral director, page 2 should	edicai Certification; To B	2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  1 Certifying I 2 Medical Extended	be 28e. Place of Injuding, et building, et b	of my know of examination	ledge, deat on and/or in	Print)	9c. Licens	se number	ath occurr	red at the time,	29d. Date s	signed (Mont	to the cause(s)

		1 - For State Registrar	State of Mary		artment of H			ene 005	17077
Physic		Decedent's Name (First, Middle, Last)	John M. P	fautz, I	II		2. Date of Death Month		3. Time of Death 10:53 AM
/Med Exam		4a. Facility Name (If not institution, give to 4607 Hunt Avenue	street and number)		4b. City, Town, or Chevy	Location of Death	may 1	4c. County of Dea	ath
Funera Directo		183-20-1980		yrs. last birthday) 19 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, April 21,		rthplace (State or Foreign country) W York
with the Maryland or 28a-f show	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgome:  10e. Street and Number  4607 Hunt Avenue		c. City, Town or Lo	nevy Chas			g. Citizen of What C	ř
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Z1Z15-UU36 ed within 72 hours af /glene. er than "natural", or t, the Medical Exern	Completed	(Specify only highest grade		(Give life. L	lent's Usual Occupa kind of work done o DO NOT use retired Lrector	lurina most of worki	ng	6b. Kind of Business Televisi	,
0 2 0 5	ø	John M. Pfautz, Ji		-			t Houge		
IVIC nd 2 : ulth ar 127 is r trau		19a. Informant's Name/Relationship (Ty)  Adrianne K. Pfautz/  20a. Method of Disposition  1 □ Burial 2 ☒ Cremation 3 □ R	Wife 20	4607 ]	Hunt Aven	ue, Chevy	Chase,	City or Town, State, Maryland Oc. Location - City or	20815
Dallimore, permit. Pages 1 ar Department of Hea Important: If item any injury or othe		' 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	е (	Crematori Ro	ium, Inc. Name and Addres bert A. H	Z00  s of Facility  Yumphrev	Funeral H	ethesda, Home/ Cha , MD 2081	esda-Chevy
Enysician /Medical		23a. Part1. Enter the disease, or complies shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Prostate	death. Do not ente	er the mode of dying	, such as cardiac o	r respiratory arres	t,	Approximate Interval Between Onset and Death 5 years
cate be executed physician and the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jesses of Mary) that initiated events resulting in death) Last	Due to (or as a con	sequence of):					
death certifi e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	ic. If yes, outcome of pre 1 Live birth 2 I 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
The law requires that the axe has been signed by the page 2 should be detached.	by	Part II. Other significant conditions con Cerebrovascular A		resulting in the un	derlying cause give	n in Part I.			o the cause of death?
The lay	Completed						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
ng Phy After this	tlon; To Be	25. Was case referred to medical examiner?  1 X Yes 2 No Ho  27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatient 28b. Time of Injury	3□ DOA Other 28c. Injury Work	at 2		ce 6	cify)
To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, stre ecify)	et, factory, office	2	8f. Location (Stree City or Town, S	et and Number or Ru State)	ıral Route Number,
To the Hospital or Al within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one)  1 ☑ Certifying Phys 2 ☐ Medical Examin	er: On the best of my er: On the basis of exam and manner stated.	knowledge, death nination and/or inv	estigation, in my opi	nion, death occurre	d at the time, date	and place, and due	to the cause(s)
F3F8		Kerin Gr.	Vealon,			3127	ŀ	Date signed (Monti	
10-71	ate	30. Name and address of person who cor Kevin G. Nealon, M	.D. 5530 W		Avenue #	925, Chev	y Chase,	Maryland	20815
Regist		WAT'Z U ZUU5	Closures .	S ASSE					

			1 - For State Registrar		aryland / De		t of H	lealth a	and M	ental Hy		9101e.	17070
			Decedent's Name (First, Middle,	Last)	- <u>-</u>					2. Date of Dea	ıth	000	3. Time of Death
	Physici /Medio		Naomi Pekmezian	ı						May 18	, 2005	Year	8:16 A. M
	Examir		4a. Fecility Name (If not institution,	give street and number,		4b. City,	Town, or	Location of	of Death		4c. Cou	nty of Death	
			4960 Sentinel Dr	ive #201			nesda	а				tgomer	У
	Funeral Director		5. Social Security Number 578-30-7245  Usual Residence of Decedent	. Sex 7. A(	ge (In yrs. last birthd 95 Yrs	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birti (Month, Day March 18	, 1910	9. Birth Cour Turk	place (State or Foreign htry) Ley
	ow ow		10a. State 10b. County		10c. City, Town o	r Location							0d. Inside City Limits
	be filed within 72 hours after death with the Maryland ntal Hygiene. od other then "naturel", or Items 23e or 28e-f show event. The Medical Examiner is use the incillied at	tor	Maryland Montgo	mery	Bethe	sda							1 ☐ Yes 2 X No
	th the	lrec	10e. Street and Number			10f. Zip	Code				10g. Citizen	of What Cou	ntry?
	23e cust b	Funeral Director	4960 Sentinel Di	ive #201		20	0816				Unite	d Stat	es
	r dea	nei	11. Marital Status	12. Was Decedent Armed Forces	7	13. Was Dece	dent of Hi cify Cuba	ispanic Ori in, Mexicar	igin? (Spe	cify Yes or No- Rican, etc.)	14. F	Race - Americ	
36	s afte	by Fu	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No	1 ☐ Yes		Specify:		,		cify: Whit	
8	hour Iture	ed b	15. Decedent's	Year or Dates:	16a De	ecedent's Usua	al Occurs	ation				Business/In	
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Maryland 21215-0036	al Hygir I other	Be	17. Father's Name (First, Middle, La	st)				18. Mothe	er's Name	(First, Middle,	Maiden Sum	ате)	
yla	should be ind Mental is marked o	70	Bedros Pekmeziar					Mar	iam (	Chaliki	an		
Nar	2 sh and Is m		19a. Informant's Name/Relationship							Route Numbe			
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Baltimore,	ages or of		1 Burial 2 XCremation 3		20b. Place of Di cemetery, o Montgon	crematory or o 1 <b>er</b> V	ther plac	e) IM	1ay 20 2005		20c. Locatio		
Ξ	it. Partimer		<ul><li>4 □ Donation 5 □ Other (Spe</li><li>21. Signature of Fuperal Service Liq</li></ul>		Cremat	orium.	Inc	• I			Bethe	sda, M	aryland
Ba	permit. Pages. Department of It importent: If ite any injury or of once.		* Ktch- L	мо								Wiscon	eral Home/ sin Avenue
H			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause ly one cause on each l	d the death. Do not ine.	enter the mod	le of dyin	g, such as	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Respiratory Failure  Due to (or as a consequence of):										
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	uted d ansit	Examine	Cause (Disease or injury that initiated events	Demen	tia								
oʻ	an an rial-tr		resulting in death) Last	Due to (or as	a consequence of):								
8760,	death certificate be executed e attending physician and id for use as the burial-transit	lcal		d.									
9	death certifics attending pl	Physician/Med	IF FEMALE:	23c If yes outcome	of programmy								
Вох	atten for us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant a	2 Fetal death	3 □Ectopic pr 5 □ Other (sp						Date of delive Month	ry Day Year
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Д.	law requires that the de as been signed by the a 2 should be detached fo	by Pl	Part II. Other significant conditions		out not resulting in the	e underlying c	ause give	n in Part I.		23e. Did to	bacco use co	entribute to th	e cause of death?
Records,	w require been sig should b	ed b	Renal Insuffici	ency						1 🗆 Y	es 2 XNo	3 ☐ Prob	abiy 4 Dunknown
000	aw re	Completed								24a. Was a		. Were auto	osy findings available
ĕ	0 L 0	Com								autops perform	Tred?	death?	npletion of cause of 2□ No
Vital	iclen: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					26. Place	of Death	(Check only on			
of <	Physiclen: this certific ral director,	To	1 ☐ Yes 2X No	Hospital: 1   Inpatie		tient 3 DO	A Othe	or: 4 □ Nu	rsing Hom	e 5 K Reside	ence 6 🗆 O	ther (Specify	)
	ing P	lon:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time y Year) Injur	У	8c. Injury Work	?		8d. Describe ho	w injury occ	urred	
isi	Attending r death. sctor: After by the fune	icat	2 Accident investigat 3 Suicide 6 Could not	be Ope Place of Inc	11 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	M		/es 2⊡1		96 Lanation (C)			
=	I or Attendate death Director:	Certification:	4 Homicide determine	building, et	ury - At home, farm, c. (Specify)	street, ractory	, опісе		20	City or Town	reer and Nur. 1, State)	nder or Hura	Route Number,
_	To the Hospitel or Attending Physicien: Within 24 hours after deactor: After this certific completely filled in by the funeral director,		29a. Certifier 1 X Certifying	hysicien: To the best	of my knowledge, de	eath occurred	at the tim	e, date and	d place, ar	nd due to the ca	ause(s) and r	nanner as et	ated.
	n 24 h	edical	(Check only 2 Medicel Ex	eminer: On the basis o and manner st	r examination and/or	investigation,	in my op	inion, deat	th occurred	d at the time, d	ate and place	e, and due to	the cause(s)
	To t To tl	ž	29b. Signature and title of certifier				License				9d. Date sigr		
)	/		mary Re	en agus		Do	C 61	65		1	May 18	, 2005	
	15		30. Name and address of person wh										
			Mary Restifo, M.	D. 3301 Nev	w Mexico	Ave. #3	342,	Wash	ingto	n, D.C.	2001	6	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 0 2	005 Bleen	ar s signature	no de							

	- State Registrar Ce	partment of Health and Mental Hy	
Physician /Medical	WIIIIam Dioya Ready	2. Date of De, Month 5 1	Day Year
Examiner	4a. Facility Name (If not institution, give street and number)  Joseph Ritchie  5. Social Security Number  6. Sex  7. Age (In yrs. last birthda)	4b. City, Town, or Location of Death  Baltimore  y) If Under 1 Year   If Under 24 Hrs.   8, Date of Birt	4c. County of Death N/A
Funeral Director	214-64-7935 1≦ M 2□F 52 Yrs. Usual Residence of Decedent	Months Days Hours Min. (Month, Day 7 ]	9. Birthplace (State or Foreign Country) 1952 MD
uth with the Marylan 23s or 28s-1 show ust be notified at	10a. State 10b. County 10c. City, Town or in MD N/A Balti		10d. Inside City Limits 1 <b>∑</b> Yes 2 ☐ No
6 after death with the Mar or items 23a or 28s-f si minar must be notified. Funeral Director	10e. Street and Number 330 E. 21st Street	21218	10g. Citizen of What Country? USA
### 1215-0036  ### 1215-0036  ### 1215-0036  ### 1215-0036  ### 1215-0036  #### 1215-0036  #### 1215-0036  #### 1215-0036  #### 1215-0036  ##################################	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ★ Never Married 2  Married  3  Widowed 4  Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1★ Yes 2  No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☐ No Specify:	14. Race - American Indian, Black, White, etc.  Specify: Black
121215-003 led within 72 hours a ygiene. her than 'natural', or with lead by Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12th  16a. Dec (Giv life.)  N/A	edent's Usual Occupation re kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
aryland 2 should ba filed and Mental Hygy as marked other umatic event, To Be Co	17. Father's Name (First, Middle, Last)	Onstruction  18. Mother's Name (First, Middle,  Jeanette	Laborer Maiden Sumame)  Ready
Mary and 2 shou salith and M n 27 is ma	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rural Route Number)  E. 21st Street Baltimor	r, City or Town, State, Zip Code)
Baltimore, Maryland 212  Bealtimore, Maryland 212  permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, Item once.  To Be Compl	`4 □Donation 5 □Other (Specify) Greenmou	position (Name of amatory or other place)  Int Crematory 5/23/2005	20c. Location - City or Town, State  Baltimore MD
Bal Bermi Permi Depar Impo Impo	The state of the s	22. Name and Address of Facility MARCH FUNE 101 E. North Avenue Balt	imore, MD 21202
Physician /Medical	23a. Part1. Enter the disease, or complications that caused the death. Do not enshow, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  At the condition of the	tier the mode of dying, such as cardiac or respiratory arr	est, Approximate Interval Between Onset and Death
examiner  Examiner  Examiner	Sequentially list appditions	·	·
176 176 Ite be Ical	Due to (or as a consequence of):		
P.O. Box 68 that the death certificated by the attending pridetached for use as the Physician/Medi	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 5	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
Cords, P mrequires that been signed b should be dera	Part 11. Other significant conditions contributing to death but not resulting in the chistory of copy because meningities, dementing		Dacco use contribute to the cause of death?  as 2 ♥No 3 □ Probably 4 □ Unknown
Wital Records, vital Records, sician: The law requires the certificate has been signed rector, page 2 should be do Be Completed by		24a. Was a autops perform 1 \square Yes 2	y prior to completion of cause of death?
, // = 5 % 5 F	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury		
Division c tral or Attending P is alter death. all Diractor: After it led in by the funera Certification;	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, str building, etc. (Specify)		reet and Number or Rural Route Number, , State)
the Hospi in 24 hou the Funer pletely fill	29a. Certifier (Check only one)  1  Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, and due to the ca vestigation, in my opinion, death occurred at the time, da	uuse(s) and manner as stated. ate and place, and due to the cause(s)
	29b. Signature and title of certifier  W. W. Dam M.D.	741476	ed. Date signed (Month, Day, Year)
3+1	30. Name and a dry s of person who completed cause of death (Item 23a) (Type, RAYMOND W, WILSON MD.; 6565 NORTH CHAR 31. Date filed (Month, Day, Year)  32. Registrar's Signature	LES ST., Suda 416, BALTIMORE	, MD 21204
State Registrar	31. Date filed (Month, Day, Year)  MAY 2 0 2005  32. Registrar's Signature	Section 1	

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Physician		State Registrer	e (First, Middle, Las		aryland / Dep <i>Ce</i>	ertificate of			Reg. No.	· W C C	1700	
/BRooklant		CLAR:			DMOND, JR.			2. Date of De Month	Day		3. Time of Dea	
/Medical Examiner		la. Facility Name (II	f not institution, give	e street and number)		4b. City, Town,	or Location of Dea			County of Deat		
		Sinai			timore	Baltin		ety		N/A		
Funeral		5. Social Security N 156–20–84		TYM 20 F	e (In yrs. last birthday 76 Yrs.	Months Days			rth ay, Year)	9. Birt	hplace (State or For untry) MD	
Director		Usual Residence of			76 Yrs.			3 1	1/ 19	29	MD	
how		10a. State	10b. County		10c. City, Town or L	ocation					10d. Inside City Lin	
liffe.		MD	N/A		Baltim	ore					1 <b>X</b> Yes 2 □	
Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or iteme 23e or 28a-f show any injury or other traumatic event, the Medical Erand art must be notified at once.  To Be Completed by Funeral Director		10e. Street and Nun 5498 (	<sup>mber</sup> Cedonia A	venue		10f. Zip Code 212	206		10g. Citi	izen of What Co USA	untry?	
or teme 236		11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of I	Hispanic Origin? (	Specify Yes or No	)-	14. Race - Ame Black, White		
y Fu			ied 2 ☑ Marned	1 X Yes 2 ☐ I If Yes, Give	No	1 ☐ Yes 2 ☒ No		no moan, etc.)		Caralta.		
turel d b	2	3 Widowed	4 Divorced  15. Decedent's Ed	Year or Dates:	160 Dog					BT	ack	
ygiene. ner then "nature t, the Medical E			ify only highest gra	de completed)	(Give	edent's Usual Occu e <i>kind</i> of work done DO NOT use retire	during most of wo	orking	16b. Ki	ind of Business/	Industry	
ther there		Elementary/Secon	ndary (0-12)	College (1-4or 5	5+)	embly Wor	_		Ma	rtin Ma	rietta	
d othe event, Be C		17. Father's Name (	(First, Middle, Last)	,		4		ıme (First, Middle				
Menta arked atic en		Clarence	e P.	Redmond,	Sr.		Edna	Web	ster			
27 is me r traums			ame/Relationship (1 Redmond-w			ing Address (Street 8 Cedonia						
item othe	2	20a. Method of Disposition 20b. Place of Disposition (Name of Complete Comp									Town, State	
nt: If		1  Burial 2 □ Cremation 3 □ Removal from State  `4 □ Donation 5 □ Other (Specify)  Arbutus Memorial Pk. 5/23/2005  Baltimore Co										
oortal / inju	T		neral Service Licen			2. Name and Addre	C: Ch.					
Depa Impo any i		▶ Bl	adus.	wan	en)	1101 E. N	Jorth Ave	ARCH FUN	imor	номе-е е, MD	AST 21202	
cian and purial-transit canimar al Examiner		resulting in death) Sequentially list cor f any, leading to im- cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	_	b. Due to (or as a Due to (or as a	a consequence of):  a consequence of):	, , , , , ,						
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If this certificate has been signed by the attending physuneral director, page 2 should be detached for use as the on; To Be Completed by Physician/Medic	2	23b. Was decedent in the past 12 in the past 12 in the past 12 in the past 12 in the past 12 in the past 12 in the past 12 in the past 11. Other significant in the past 12	icant conditions of the No.  T	Ho spital: 1 Place of Injur (Month, Da)  28e. Place of Injur (building, etc.)	2 Fetal death 3 I time of death 5 I time of death 5 I time of death 5 I time of death 5 I time of death 5 I time of death 5 I time of year) 28b. Time of Injury 28b. Time of Injury 20th of my knowledge, deat examination and/or in	Other (specify)  Int 3 DOA Other  A 28c. Injury  M 1 reet, lactory, office	26. Place of Dener: 4 □ Nursing Hy at tk? Yes 2 □ No	24a. Was autor performent of the control of the con	obacco us Yes 2 an an sy rmed? 2 (1 No one) dence 6 now injury Street anc wn, State) cause(s) date and	Month  se contribute to  3   Pro  24b. Were aut prior to or death? 1   Yes  Coccurred  A Number or Rui	the cause of death?  that a large of death.  that a la	
ss been signed by the attending phys 2 should be detached for use as the pieted by Physician/Medic	2	23b. Was decedent in the past 12 in the past 12 in the past 12 in the past 12 in the past 12 in the past 12 in the past 12 in the past 12 in the past 12 in the past 12 in the past 12 in the past 12 in the past 12 in the past 12 in the past 13 in the past 13 in the past 14 in the past 14 in the past 14 in the past 12 in	icant conditions of the No.  T	Ho spital: 1 Place of Injur (Month, Da)  28e. Place of Injur (building, etc.)	2 Fetal death 3 I time of death 5 I time of death 5 I time of death 5 I time of death 5 I time of death 5 I time of death 5 I time of year) 28b. Time of Injury 28b. Time of Injury 20th of my knowledge, deat examination and/or in	other (specify)  Inderlying cause given to a specific cause given to a	26. Place of Dener: 4 □ Nursing Hy at tk? Yes 2 □ No	24a. Was autop performent of the control of the con	obacco use Yes 2 1 an an an an an an an an an an an an an	Month  se contribute to  3 Pro  24b. Were aut prior to or death? 1 Yes  Cocurred  A Number or Run  and manner as place, and due to	Day Year  the cause of death?  bably 4 Unkno  opsy findings availa  pmpletion of cause  2 1 1 0  ify)  al Route Number,  stated, to the cause(s)  Day, Year)	

			For State of Maryland / Depart State of Maryland / Depart Cert	rtment of Health and M tificate of Death	lental Hygie	-000
	Physicia		Decedent's Name (First, Middle, Last)  Warren Earl Ruth		2. Date of Death Month	Day Year 3. Time of Death
	/Medic Examin		4a Fapility Name (If not institution, give street and number)  HANCS HEALTH COVE	4b City, Town, or Location of Death	7.10	4c. County of Death
	Funeral Director		5. Social Security Number  6. Sex. 7. Age (In yrs. last birthday)  218-28-2019  Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 05 / 25 / 1	
yland	Mot		10a. State 10b. County 10c. City, Town or Local	ation		10d. Inside City Limits
эө Маг	8a-fal	Director	MD Baltimore City Baltimore			1) Yes 2□No
with th	a or 2 by na	Dire	10e. Street and Number	10f. Zip Code		Citizen of What Country?
death	ns 23	Funerai	271 McCurley Street           11, Marital Status         12. Was Decedent Ever in U.S.         13. W	21229 as Decedent of Hispanic Origin? (Spe	cify Yes or No-	nited States 14. Race - American Indian,
<b>21215-0036</b>	of Health and Mental Hygiene. itam 27 ta marked other than "natural", or Items 23a or 28a-f ahow other traumatic avant, I'm Medical Examinat must be malified at	þ	1 Never Married 2 Married 1 Yes 2 No	Yes, specify Cuban, Mexican, Puèrio i □ Yes 2 No Specify:	Rican, etc.)	Black, White, etc.  Specify: White
<b>5-0</b>	natur	eted	(Specify only highest grade completed) (Give ki	ent's Usual Occupation ind of work done during most of working	ng 161	b. Kind of Business/Industry
7121 within	than	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Mainte	O NOT use retired)	Uı	nknown
<b>5 5 6 9 9</b>	other vant, l	Be C	17. Father's Name (First, Middle, Last)		(First, Middle, Mai	den Sumame)
Maryland d 2 should be tile	Menta arked atic a	2	Earl Ruth	Ester Mo	onks	
Mar 12 sh	h and 7 Ia m traum			Address (Street and Number or Rura		, , , , , , , , , , , , , , , , , , , ,
<b>.</b> 1 an	Healt tarn 2 other		20a Method of Disposition 20b. Place of Disposi	Heavenly Acres R		COCK, MD 21750 Location - City or Town, State
m Pages	nt: if i		1 Buriai 2/3 Cremation 3 Hemoval from State	e Crematory Inc. 2	May 20	eltsville, Maryland
Baltimore,	Department of the limportant: If its any injury or of once.	İ	21. Signature of Funeral Service Licensee 11098( 22.	Name and Address of Facility emation and Funeral		
Pn.	ysician Medical aminer		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	17 Green Pastures I the mode of dying, such as cardiac o	Drive Bal	timore, Maryland 21286
58760, <b>C</b> icate be executed	in and ial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	7 Cardiova	20101	Discos mercing
PRECORDS, P.O. Box 68 The law requires that the death certific	70 m	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year
Varre ords, P	engi pe q	þ	Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I.	23e. Did tobace	co use contribute to the cause of death?
	2 2	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1   Yes 2   No
Vita	- S	Be	25. Was case referred to medical examiner?	26. Place of Death		
vision of Vita	fter this meral di	on: To	1   Yes   Hospital: 1   Inpatient   The Inpatient   Yes   Yes   The Inpatient   The Inpatient   The Inpatient   28a. Date of Injury   28b. Time of Injury	28c. Injury at 2 Work?	ne 5 🗌 Residence 28d. Describe how in	e 6 Other (Specify) njury occurred
Division for Attanding	winin 24 hours after death.  To the Funeral Director: A completely filled in by the to	ertification;	2 ☐ Accident     investigation       3 ☐ Suicide     6 ☐ Could not be determined       4 ☐ Homicide     determined       28e. Place of Injury - At home, farm, stree building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No et, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, late)
Hospital	Z4 nours 24 nours 3 Funeral etely filled	edical Ce	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death of the basis of examination and/or invegand manner stated.	occurred at the time, date and place, a stigation, in my opinion, death occurre	and due to the cause and at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the	To the	₩e	29b. Signature and title effectifier	29c. License number	29d.	Date signed (Month, Day, Year)
			Afrading Physician	D51853	$\sim$	10, 18, 2005
21	1	1	30. Name a address of person who completed cause if death (Item 23a) (Type, Pr	D Caton Av	enve t	Soltinon 2229
	Stat Registra	e ar	31. Date filed (Month, DAY 291) 2005 32 fegistrar's Signature			

			For State Registrer	State of M	aryland / De	epartment of be continued by the continu	lealth and M	1ental Hygi	•	17082
	Physici		1. Decedent's Name (First, Middle, CHZISTOPH	•	>			2. Date of Death Month MAN	Day Year	3. Time of Death 3: V5 AM
	/Medio Examir		4a. Facility Name (If not institution, UNIVERSITY OF				or Location of Death		4c. County of Death	
	Funeral Director		030-52-4992	6. Sex 7. Ag 1 1 M 2 □ F	ge (In yrs. last birtho 40 Yr.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, AUG • 20	Year) 9. Birthr Cour 1964 Oh	place (State or Foreign htry)
	yland how		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location			1	0d. Inside City Limits
	he Mar	Director	MD Howa:	rd	Columbi					1 ☐ Yes 2 No
	3a or 2		10e. Street and Number 8117 Sea Water	Path		10f. Zip Code 21.045		10	g. Citizen of What Cour	ntry?
980	be filed within 72 hours after death with the Maryland nat Hygiene. od other then "natural", or Iteme 23a or 28e-f show event, the Medical Exantrae must be routified at	by Funeral	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?		13. Was Decedent of Hif Yes, specify Cub	dispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
Maryland 21215-0036	within 72 ho ene. then "natur	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)	(0	ecedent's Usual Occup Give kind of work done fe. DO NOT use retire	during most of work	ing	6b. Kind of Business/Ind	dustry
121	e filed within al Hygiene. I other then vent, the Me		17. Father's Name (First, Middle, L	4		Civil Eng			Land Develo	pment
and	should be f nd Mental H marked of	To Be	Francis Joseph				18. Mother's Name			
lary	2 should and Men le marke reumatic		19a. Informant's Name/Relationsh	р (Туре, Print)					City or Town, State, Zip	Code)
	item 27		Suzanne Zarin  20a. Method of Disposition			7 Sea Wate:			MD 21045  Oc. Location - City or To	wn State
mor	Pages nent of I ant: If its ary or o		1 ☐ Burial 2 🏋 Cremation  4 ☐ Donation 5 ☐ Other (Sp.		l	isposition (Name of crematory or other place re Wash. C		2	Laurel, MD	wii, State
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 le marke eny injury or other treumatic QDC8.		21. Signature of Funeral Service L			22. Name and Addre	ss of Facility Ifman Fune	eral Home	e @ Meadpwri	dgeMP, Inc.
	Physician /Medical	83 III)	23a. Part1. Enter the disease, or of shock, or heart failure. List of limmediate Cause (Final disease or condition resulting in death)		the death. Do not ne.	enter the mode of dying	ng, such as cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death 3 DKYS
3760,	physician and sthe burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause for the condition of the c	b	a consequence of): a consequence of): a consequence of):	:				
.O. Box 68	death certif e attending id for use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 🗌 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delive Month	ry Day Year
rds, P	quires that in signed b		Part II. Other significant condition	s contributing to death b	ut not resulting in th	ne underlying cause giv	en in Part I.		cco use contribute to th	/
tal Records,	icien: The law requires that the certificate has been signed by th rector, page 2 should be detache	• Completed	25. Was case referred to medical					24a. Was an autopsy performe	prior to condeath?  No 1 Yes	osy findings available inpletion of cause of 2 No
of Vital	S &	To Be	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie	ry 28b. Tim	atient 3 DOA Oth	4   Nursing Hor		ce 6 ☐Other (Specify	)
Division	Attending Physicien: r death. sctor: After this certifici	Certification;	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no determin	t be 28e. Place of Inju	ury - At home, farm	ry Wor	k? Yes 2□No		et and Number or Rura	Route Number,
Ö	itel or rel Dire	Cert	4   Hornicue	building, etc				City or Town,	•	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	Medicai	one)	Physician: To the best of ceminer: On the basis of and manner sta	examination and/o	or investigation, in my o	pinion, death occurre	ed at the time, date	e and place, and due to	the cause(s)
<b>!</b>	To To	<	29b. Signature and title of certifler	240 R	GSIDENT PH	29c. Licens AUUF			1. Date signed (Month, L	
	20		30. Name and address of person w	no completed cause of de 22 5 GR4	eath (Item 23a) (Ty	pe, Print) REST BAC	IIMONE	MO 21	201	
	Sta Registr	100	31. Date filed (Month, Day, Year) MAY 2 0 20	05 As2. Registra		W.				

			1 - For State Registrar	State of Marylar	•	artment tificate				Reg.	ne no.200	5 17083
-	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last     Norbert John     Aa. Facility Name (If not institution, give	Rosenberger				ocation of D	2. Date of Month May		2005 4c. County of E	6:00 p. M
	Funeral Director		Genesis Perring  5. Social Security Number 212-03-2922 6. Security Number	x 7. Age (In yrs.	last birthday) 8 Yrs.	If Under 1		rille  If Under 24   Hours   N	Hrs. 8. Date o	f Birth Day, Ye		more Co.  Birthplace (State or Foreign Country)  Maryland
	Ba-f ehow	Director	Usual Residence of Decedent		ty, Town or Lo	re					02:	10d. Inside City Limits 1 \ Yes 2 \ No
	death with ti ms 23a or 2	Funerai Dire	10e. Street and Number 3204 Evergreen  11. Marital Status	Avenue  12. Was Decedent Ever in U	J.S. 13.	Vas Decede	2	21214	? (Specify Yes o			States umericen Indian,
-0036	72 hours after death with the Maryland Instural, or Items 23e or 28e-f ehow Jisal Examinational buncillists at	by	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Edi	1 ∐Yes 2 ∐XNO If Yes, Give Year or Dates:	16a. Dece	1 ☐ Yes 2	No Occupat	Specify:				White, etc. White
121215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. ed other then "natural", or Items 23s or 28s-1 show event, the Maxical Exprinter right by notified at	Completed	(Specify only highest grades) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+) 4 yrs.	life.	kind of work DO NOT use nginee	e retired)	uring most of	working Name (First, Mi			f the Navy
Maryland	2 should be fi and Mental F ie marked of aumatic ever	To Be	•	senberger ype, Print)	19b. Mailir	ng Address		Mar		Costo	hryz	e, Zip Code)
Baltimore, M	of Health of Health Item 27		Mrs. Rita C. Pollo  20a. Method of Disposition  1  Burial 2  Cremation 3    4  Donation 5 Other (Specify	20b.   Removal from State	Place of Dispo cemetery, crer	sition (Nam natory or oti	e of her place		Date	200	. Location - City	
Baltin	permit. Fage Department of Important: If eny injury or		21. Signature of Funeral Service Licent	Michael E. Car		Leon	ard	of Facility J. Ruc	y 21, 20 ck, Inc.		Baltimo 5305 Han Baltimon	rford Rd. re, MD 21214
	Physician /Medical Examiner		23a. Part1. Enter the disease, of comp shock, or heart failure. List only of Immediate Cause (final disease or condition resulting in death)	lications that caused the dealine cause on each line.  a	lon			such as car		ory arrest,		Approximate Interval Between Onset and Death
1760, <	te be executed ysician and he burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect of the to (or a) consect of the to (or a) consect of the to (or a) consect of the to (or a) consect of	guence of: State quence of):				nine	<u> </u>		
.O. Box 68	it the death certificat by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 6 9 □ Unknown	al death 3	Ectopic pre Other (spe				_	23d. Date of Month	delivery Day Year
S, D	The law requires that the to the law requires that the to been signed by the bage 2 should be detache	by	Part II. Other significant conditions of	entributing to death but not res	sulting in the u	nderlying ca	iuse giver	n in Part I.				e to the cause of death?  ] Probably 4 ①Unknown
of Vital Record		e Completed	25. Was case referred to medical					26 Blace of			prior deat	e autopsy findings available to completion of cause of h?  Yes 2 No
on of Vit	Phys this ral dii	To B	examiner? 1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury		A Other Bc. Injury Work	4 Nursir	ng Home 5 🗆 I	Residence	e 6 Other (S	Specify)
Division	or Atten ifter deat Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	lome, farm, str fy)			55 2 2 100		on <i>(Str</i> ee r Town, S		r Rural Route Number,
	To the Hospital or At within 24 hours after C To the Funeral Direc completely filled in by	Medical	29a. Certifier (Check only one)  1 Certifying Physical Example one)  2 Medical Example of certifier 2	/sician: To the best of my kn iner: On the basis of examin- and manner stated.	owledge, deat ation and/or in	vestigation,	in my opi	nion, death o	occurred at the t	me, date	and place, and Date signed (M	due to the cause(s)
)	6	To add and a second sec	30. Name and address of person who d	touding Drompleted cause of death (Ite	m 23a) (Type.	Print)	D	536	(42	1	lay 1	92005 -,mo21239
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 0 20	32 Registrar's Sign 05	ature	h ICO	1.19	n Dl	00 3	· ノ	Palt	mozics

			_ FOI	partment of Health and M		_	oie.	1 70	0.1
			Registrar	ertificate of Death		Rag. No. U		1/1	84
Н	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Dea Month 5/16/2	Day	Year	3. Time of 10:00	Death P M
	/Medic	cal	Thelma R. Romer  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	3/16/2	4c. County	of Death	10:00	T ivi
	Examir	ier		Cheverly		Prince		orges	
	Funeral		Prince Georges Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		8. Date of Birt			place (State or	r Foreign
	Director		230-46-3507 1 M 2 XF 70 Yrs.	Months Days Hours Min.	8. Date of Birt (Month, Day 5 / 26 / 19	34 (		itry) esse	
	pu »		Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or					Od Luid Oit	. I imple
	shored	ō						0d. Inside Cit N☐ Yes	
	the N	ecto	Maryland Prince Georges Upper Ma  10e. Street and Number	11DOTO		10a Citizon of M	flact Cour		
	with	ρ	10145 Campus Way South	20774		10g. Citizen of W JSA	mat Cou	ntry /	
	Jeath ms 23	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto			- Americ	an Indian,	
9	aftar or itar	T.	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No		Rican, etc.)	Black	k, White,		
8	rel', c	l by	3 ▼ Widowed 4 □ Divorced If ∀es, Give Year or Dates:	1 ☐ Yes 2√☐ No Specify:		Specify:	Whi	te	
5-0	72 h	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of work DO NOT use retired)	ing	16b. Kind of Bu	siness/In	dustry	
121	within noe. han '	dm	Elementary/Secondary (0-12) College (1-4or 5+) Scho	ol Teacher		Educat	ion		
d 2	filed Hygie Hygie than than		17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle.				
an	ld ba ental ked o	To Be		Annie Ma			-,		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "neturel", or items 23e or 28e-f show reumatic event, the Medical Examiner must be netilied at	1		ling Address (Street and Number or Rura		r, City or Town, S	State, Zip	Code)	
	1 and 2 Health a Iem 27 is			5 Campus Way South					
Baltimore,	S == 0		20a. Method of Disposition 20b. Place of Disposition		Date	20c. Location - 6			
Ē	Pages nent of I			inity	2005	Waldorf,	MD		
alti	arth orte			22. Name and Address of Facility Ro				al Hom	e
<u> </u>	Depart Impo		ph from 1	6000 Annapolis Roa	d Bowie	, MD 207	15		
760,	/Medical Examiner burial-transit sthe burial-transit	cal Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, Tarry, washing to minimal to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Luct (rasadoracuse of):  c. Coronary Artery Due to (or as a consequence of):	ibrillation				Interval Betw Onset and D	
P.O. Box 687	it the death certif by the attending tached for use a	Physician/Medic	In the past 12 months?  1 □ Yes 2 ▼ No 9 □ Unknown  4 □ Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)	aza Did ta	23d. Date Mon	ith	Day Y	ear
rds,	quires the en signed ould be de	ed by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		es 2 No			
Il Records,		Completed			24a. Was autop perfor 1 Yes	sy pi med? de	Vere auto rior to cor eath? Yes	psy findings a npletion of ca 2 No	vailable use of
Vital	rysicien: Th nis certificate director, paç	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death	(Check only or	16)		-	
of	Phys this al dii	To To	1 ☐ Yes 2 ☒ No ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No			ence 6 Othe		()	
	ing After une	tion	1 X Natural 5 ☐ Pending (Month, Day Year) Injury		200. Describe II	ow injury occurre	eu .		
Division	or Attending after death. Director: After d in by the fune	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s		28f. Location (S	treet and Numbe	or or Rura	l Route Numb	oer,
Ö	after after Direct	Certification:	4 Homicide determined building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	City or Tow	n, State)			
	To the Hospitel or Al within 24 hours after of To tha Funeral Direc completely filled in by	Medical C	29a. Certifier (Check only one)  17 Certifying Physician: To the best of my knowledge, decorated and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the deed at the time, o	ause(s) and mar late and place, a	nner as si	ated. the cause(s)	
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	29c. License number	2	29d. Date signed	(Month,	Day, Year)	
	-		> Stuntin	D46998		5/19	120	SOC	
	10		30. Name and address of person who completed cause of death (Item 23a) (Type Dr. Steven Tee 3415 Hamilton Street		lle, MD	20782			
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 2 0 2005  32. Figistrar's Signature		<del>-</del>				
			min w o 2000 June 1	40.000					

			1- State of Maryland / Department of Healt Certificate of Dea	ath	Reg	2000	17085
ı	Physici		1. Decedent's Name (First, Middle, Last)  Gautam K. Roy		Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Locat		1234	4c. County of Deat	
			Doctor's Community Hospital Lanham			Prince Ge	orge's
	Funeral Director			Jnder 24 Hrs. 8. ours Min. O	Date of Birth (Month, Day, Yo	9. Birt	nplace (State or Foreign untry) 1.3
	-		Usual Residence of Decedent				
	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-f show is Nedicul Evaniner must be notified at	lor					10d. Inside City Limits 1 XYes 2 No
	r 28a	Funeral Director	10e. Street and Number 10f. Zip Code		10g	. Citizen of What Co	untry?
	th with	alD	11213 Fruitwood Drive 20720		Ur	nited Star	es
	ter dea Items	ner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispania If Yes, specify Cuban, Mexical Information I	nic Origin? (Specif exican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit	
36	rrs afte	by Fu	1 ☐ Never Married 2 [X] Married 1 ☐ Yes 2 [X] No If Yes, Give 1 ☐ Yes 2 [X] No Spe 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	pecify:			an Indian
5-0036	72 hours "natural",	ted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during	a most of working	16	b. Kind of Business/	Industry
2	ithin 7 ne. nan "r	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Structural Engine				
72	filed w Hygier other th					onstructi	on
Maryland	s 1 and 2 should be filed within 72 ho of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, tha Medical	To Be	Political Para	Mother's Name (F Sasanti	(Unknow		
Man	d 2 sho	15	19a. Informant's Name/Relationship ( <i>Type</i> , <i>Print</i> )  Gopa Roy/Wife  19b. Mailing Address ( <i>Street and No.</i> 11213 Fruitwood				Tip Code)
ر ق	Health tem 27 other tr		20h Place of Disposition (Mama of	Date		c. Location - City or	Town, State
Ë			1 Burial 2 X Cremation 3 Removal from State  1 Donation 5 Other (Specify)  1 Donation 5 Other (Specify)	May 19 200		thesda,	Maryland
Baltimore,	permit. Pag Department Important: f any injury o		21. Signature of Funeral Service Licensee  M01353  22. Name and Address of F Bethesda-Chev Bethesda, Mar	Facility Robe: 7y Chase: 7y1and 20	rt A. Pu Inc. 7 0814-350	mphrey Fu 557 Wisco 1	neral Home/ nsin Avenue
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. End Stage Book or iv	n Tu	espiratory arrest		Approximate Interval Between Onset and Death
8760,	Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death.  Funeral Director: After this certificate has been signed by the attending physician and selly filled in by the funeral director, page 2 should be detached for use as the burial-transit.	dical Examiner	d	9			years years
P.O. Box 6	it the death certific by the attending p tached for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)			23d. Date of del Month	very Day Year
	quires tha n signed I uld be det			Part I.	23e. Did tobac	~	the cause of death?
Division of Vital Records,	The law requireste has been sipage 2 should b	Completed by	Severe Hyponatzemia		24a. Was an autopsy performed	prior to d	topsy findings available ompletion of cause of
a	ician: Th certificate rector, pag	e Co		Place of Death (C	1 Yes 2	No 1 ☐ Yes	2 No
>	ysician: is certific director,	0 0	examiner?			e 6 Other (Spec	eifv)
0 0	ding Ph h. After th funeral	on: T			d. Describe how		,,
Sio	Attendin death. ctor: Afi y the fur	catl	2 Accident investigation 3 Suicide 6 Could not be				
) A	s after d al Direct ad in by	Certification:	4 ☐ Homicide  3 ☐ Suicide  4 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  5	28f	Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical (	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, dat 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, and manner stated.	ate and place, and n, death occurred	d due to the caus at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier Raketh anang MD 29c. License number 29c. License			Date signed (Mont)	
	D		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  RAKIESH AKOKA M. J. 14360 CALLANT FOX L  31. Date filed (Month, Day, Year)  22. Registrar's Signature	ANE KI	ובנ אווי	BD: 115	und 20715
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 2 0 2005  MAY 2 0 2005			p-wici	~

			For State Registrar	State of M	aryland	d / Depa		of He	ealth a		-		401	) 5	17086
	Physici /Medic Examin	al	Decedent's Name (First, Middle, HILDA     HILDA     Aa. Facility Name (If not institution,	RUTH give street and number)		R0	STOV 4b. City, To	own, or				8, <sup>Da</sup>	005 . County o	Year f Death	3. Time of Death 12:12 A <sup>M</sup>
	Funeral Director		BRIGHTON GARDE  5. Social Security Number 212-32-3303  Usual Residence of Decedent		e (In yrs. I. 93	ast birthday) Yrs.	if Under 1 Months	Year Days	PIKE If Under 2 Hours		B. Date of Bir Month, Da JAN. 3	191	2	9. Birthp Coun	BALTIMORE lace (State or Foreign try) POLAND
	the Maryland 28a-f show otified at	ector	10a. State 10b. County	ALTIMORE	10c. City	PIKE	SVILLI					10a Ci	tizen of Wi		0d. Inside City Limits 1 ☐ Yes 2 No
0036	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or Items 23a or 28a-f show unatic event, the Medical Evanting must be notified at	d by Funeral Director	1840 REISTERS  11. Marital Status  1 Never Married 2 Marrie 3 X Widowed 4 Divorced	12. Was Decedent Armed Forces? d 1 \( \text{Yes} \) 2 \( \text{Yes} \) If Yes, Give Year or Dates:	Ever in U.	.	Was Deceder If Yes, specify 1 ☐ Yes 2	nt of His y Cubar	Specify:		ecify Yes or No Rican, etc.)	)-	14. Race Black Specify:	- Americ , White,	USA an Indian, etc. WHITE
121215-0036	filed within 72 t Hygiene. Ither than "natu ant, 'ne Wedica	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 17. Father's Name (First, Middle, L	grade completed)  College (1-4or 5	5+)	(Give	dent's Usual of kind of work DO NOT use	done di retired)	uring most		ng o (First, Middle	BAL.		E CI	SCHOOLS TY PUBLIC
Maryland	ould be f Mental H larked of	To Be	JACOB			RUB]			DIN	4				SCHI	CHMAN
Baltimore, Ma	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 Is marke any injury or other traumatic <u>once</u> .		19a. Informant's Name/Relationsh  DEBRA ROSTOV  20a. Method of Disposition 1 X Burial 2 ✓ Cremation 4 □ Conation 5 ✓ Other (Sp.	DAUGHTER  Ballemoval from State scify)  Contact the state scify and state scify and state scify and state scify and state scify and state scify and state scify and state scify and state scientific and state scify and state science scify and state science scify and state science	SHA	43 Elace of Disposementery, crem	SLONDEI esition (Name natory or oth ZION CI 2. Name and 900 RE	of er place EM. Address	COURT  (a)  (b)  (c)  (c)  (c)  (d)  (d)  (d)  (d)	- T 05/1 SOL	I MONIUM I MONIUM Pate 9/2005 LEVINE	ROSON PIKE	D 210 ocation - C OSEDA & BRC	93 LE, DS.,	wn, State
3760,	The law requires that the death certificate be executed xx xx xx xx xx xx xx xx xx xx xx xx xx	ical Examiner	23a. Part. Enter the disease, or shock, or heart failure. List of limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a	a consequ	uence of):	D) SEA		, such as c	ardiac c	я гезрігатогу а	rrest,			Approximate Interval Between Onset and Death
O. Box 68	it the death certifica by the attending pt tached for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a	2 Fetal	death 3	Ectopic preg						23d. Date Mont		ry Day Year
rds, P.O	w requires that the been signed by should be detact	by	Part II. Other significant condition	s contributing to death b	ut not resu	ulting in the u	nderlying cau	ise givei	n in Part I.			obacco Yes 2			e cause of death?
al Records,	nysician: The law re nis certificate has be i director, page 2 sho	e Completed	OF Was again relayed to madical								1 ☐ Yes	psy prmed?/ 2 No	de	ath?	psy findings available inpletion of cause of 2 No
of Vital	Physicial r this certi sral directo	To B	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death	Hospital: 1 Inpatie		ER/Outpatier		Other	r. 4 Nur	rsing Hor	n <i>(Check only o</i> me 5 ☐ Resi 28d. Describe	dence			()
Division	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification:	1 Natural 5 Pending investige investige 3 Suicide 4 Homicide	ot be as Blace of Ini	ury - At ho	Injury me, farm, str	М	1 🗆 Y	? es 2□N	-	28f. Location ( City or To			or Rura	l Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best xaminer: On the basis o and manner st	f examinat	wledge, death ion and/or in	n occurred at vestigation, in	the time	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s date an	) and mani d place, an	ner as st id due to	ated. the cause(s)
	To the within To the Comp	Me		prom.D,					number	6)			le signed		Day, Year)
	V		30. Name and address of person w	,n.0 21 (ros	isroads	100	= 400 C	ר וריים ק	95 Mi	115,1	10 211	17			
	Sta Registi		31. Date filed (Month, Day, Year)  MAY 2 0 20	22. Registr	ars Signat	Asset	the s								

DHMH 17 Rev 1/2001

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			For State	State of M	laryland / Dep	partment of the partificate of			an a a	17087
			1. Decedent's Name (First, Middle	[ast]		sitincate of	Dealit	2. Date of Death	lo.	3. Time of Death
11	Physicia	an			la =	On in		Month	2 7/9/0	- 123QM
	/Medic		Victor  4a. Facility Name (If not institution)		hony		er Sr. or Location of Death	ing is	Ic. County of Dea	<i></i>
	Examin	er	MARAIANA 6	General	Wiso Hal	Palti	nove Ci	ty		
	Funeral		5. Social Security Number		ge (In rs. last birthda	y) If Under 1 Year Months Days		8. Date of Birth (Month, Day, Yea	9. Bir	thplace (State or Foreign ountry)
	Director		213-32-8128	<b>X</b>	66 Yrs.	Monais Days	, iodio iviiii	06 06	38	М́D
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mary f sho	tor	MD NA		Baltim	ore				XXYes 2 ☐ No
	r 28a	Funeral Director	10e. Street and Number			10f. Zip Code		10g. (	Citizen of What Co	ountry?
1	h with	JE D	605 George St	reet Apt	6	23	1201		U.S.A	. •
0	deat	ner	11. Marital Status	12. Was Decedent		. Was Decedent of	Hispanic Origin? (Special, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, Whi	
So Co	172 hours after death with the Maryland "naturel", or Items 23a or 28a-f show colcal Examiner must be notified at	/ Fui	XXNever Married 2☐ Marri	ed 1 □ Yes 2 🔯 If Yes, Give	No	1 ☐ Yes 2√ No		rticari, etc.)	Specify:	le, etc.
5-0036	hours ural',	d by	3 Widowed 4 Divorced	Year or Dates:		cedent's Usual Occu		165	Kind of Business	lack
15	"na"	Completed	15. Decedent (Specify only highes	t grade completed)	(Gi	ve kind of work done  . DO NOT use retire	durina most of worki			louse and
25	itled within Hygiene. other than	ome	Elementary/Secondary (0-12)  12th grade	College (1-4or		rounds F	Keeper	Gai	rden Ap	ts.
פ	e filec of he vant,	Be C	17. Father's Name (First, Middle,					(First, Middle, Maide		
la 🔊	uld by Menta priked	To E	John Spicer				<del></del>	Brooks		
MUTAR Sire, Maryland 21	s 1 and 2 should be filed withi f Health and Mental Hygiene. Itam 27 is marked other than other traumatic evant, the M		19a. Informant's Name/Relations Marie Spicer -							Zip Code) 21133
, ~ (c)	1 and 2 Health lam 27 i			Daughter		o Calliago position (Name of			2 Kanda Location - City or	11stown, Md
20	Pages 1 nent of H int: if ita iry or of		20a. Method of Disposition 1		cemetery, c	rematory or other pla	ace)		,	
	it. Pa rtmer rtant: njury		<ul> <li>4 □ Donation 5 □ Other (S)</li> <li>21. Signature of Funerat Service</li> </ul>		King M	emorial 22. Name and Addre		21/05 Rai	ndallst	own, Md
Bal	permit. Pages 1 an Department of Heal Important: if Itam 2 any injury or other once.		21. Signature of Fullerac Service	Le K.	and a	March F	/H West	5.1.1	34.7	21215
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	ed the death. Do not e	4300 Walk enter the mode of dy	Dash Ave , ing, such as cardiac c	Baltimo or respiratory arrest,	ore, Ma	Approximate
	nysician -		Immediate Cause (Final	Alhonn	solorntin	Cardini	nsnilar	Disea:	5-0	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or a:	s a consequence of):	· Carallo	mumice	/2 0 0		
	Examiner		Compatible list conditions	b						
	ש א	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequence of):					
1	icate be executed physician and s the burial-transit	Examine	that initiated events resulting in death) Last	c. Due to (or a)	s a consequence of):					
8760,	be ex ician burial	al E		500 10 (5) 4.	3 & 55/1354851155 51/.					
687	icate phys s the	dical		d						
	certif nding Ise a	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom					23d. Date of de	livery
B	death d for	iciar	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnant a		B □Ectopic pregnand  □ Other <i>(specify)</i> _	су		Month	Day Year
0.	t the c by the	Physician/Me	9 Unknown	9□ Unknown						
Division of Vital Records, P.O. Box	The law requires that the death certifi ste has been signed by the ettending p page 2 should be detached for use as	ру Р	Part II. Other significant condition	ns contributing to death	but not resulting in the	underlying cause g	iven in Part I.			o the cause of death?
ord	equir							1 Tes	2 □ No 3 □ P	robabły 4 Winknown
မင်င	law r as be	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u> </u>	sician: The law certificate has b irector, page 2 s	Con						performed	death?	2 □ No
/ita	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		0.		(Check only one)		
of \	Q 18.	. To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpat	^			me 5 Residence 28d. Describe how in		ecify)
uo	ding h. After funer	tion	1 Natural 5 Pendin 2 Accident investig	g (Month, D	ay Year) Injur	/ Wo	ork? ∃Yes 2⊟No		jary sosamos	
isi	Attsn deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could of	not be 28e. Place of Ir	njury - At home, farm,			28f. Location (Street		ural Route Number,
Div	al or safter	Certification:	4  Homicide	building, e	atc. (Specify)			City or Town, Sta	110)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	ledical C		g Physician: To the bes Examinar: On the basis						
	the I	Medi	one) 29b. Signature and title of certifier	and manner s	stated.	29c Licen	nse number	294 [	ate signed (Mon	th Nav Vasri
	S J K J		250. Signature and the or certifier	1	MIT	1/1	OCKAT	. 5	1/13/6	5
	1		30, Name and address of person	who completed cause of	death (Item 22a) (Tue	e Print)	1703		1100	722
	り		Lideat Ali	, M.D. 82	MD death (Item 23a) (Typ IN EWA)	NST. SI	ute 103	Baltin	oce ML	1.0101
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regis	trar's Signature					
	Registr	ar	MAVGA	2005	1.0	- A D				

DHMH 17 Rev 1/2001

ORIGINAL

ADH VERNON SAUNDERS 05-3323

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2005 Year **Physician** 13 PM MAY 1401 soun ders ernon /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Director Usuel Residence of Decedent 10a. State 10b. County 10d. Inside City Limits s 23e or 28a-f show ust be notified at 1 Yes 2 □ No MD Director 1 more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1506 21212 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or Items r than "natural", or Items the Medical Executive to 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than 'any injury or other traumatic event, Ite Ma. Elementary/Secondary (0-12) College (1-4or 5+) 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sur argare 19a, Informant's Name/Relationship (Type, Print) Rural Route Number, City or Town 19b. Mailing Address (Street and Number of Brother 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) louni Green 22. Name and Address of Facility
Voughn C. Greene Funeral Sves
\$725 Liberty Road, Randa Kstun, MD21133 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiae or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** INTURIES BUNT FORLE KEAD /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. The Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medicai the ass attending | IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) detached Records, P.O. the 9 Unknown 9 Unknown ģ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🗷 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: X Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No 2 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27 Manner of Death Certification: After 5 Pending investigation 1 Natural SUBTECT 2AW death. 3:43 P 1 ☐ Yes 2 🔀 No 5/11/05 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 200 HERRING CT, BALTIMORE, MD STREET BUK 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number OCME MAY 14, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Name (First, Middle, Lest) 3. Time of Death Month SCHUMACHER HILDA JUHNITA 2005 5:20 AM May 18 4a Fecility Name (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Deeth BALTIMORE CITY BALTIMORE CENTER HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. lest birthday) 1 □ M 2 XF Yrs. 89 April 13, 1916 Maryland Usuel Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 □ Yes ŽŽ No Maryland Baltimore Halethorpe 10g. Citizen of Whet Country? 10f. Zip Code United States of America 21227 3006 Virginia Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes ŽXNo if Yes, Give Year or Dates: 1 Never Married 20X Married 1 □ Yes XX No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Lest) Earl R. Cook Ethel R. Bennett 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) 3006 Virginia Avenue; Juanita L. Clopien (Daughter) Halethorpe, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date May 21, 2005 XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Ofther (Specify) Loudon Park Cemetery Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Avenue Baltimore, Maryland Approximate Interval Between Onset and Death Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on eech line. WKS

**Physician** /Medical Examiner

usa as the burial-transit

Examiner

Be Completed by Physiclan/Medical

edical Certification: To

Department of important: If it any injury or o

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nant of Health and Mantal Hygiena. Int: If Item 27 is marked other than "natural; or items 23a or 28e-f show

al Hygiena.

item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Medical Examiner must be notified at

HARBOR

216-72-4522

10e. Street end Number

5th

11. Marital Status

10a. State

Directo

Funeral

þ

Completed

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last

Immediate Cause (Final disease or condition resulting in deeth)

Due to (or as e consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I COPD

23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

				Ĺ		The	165	7
26.	Place	of	Death	(Ch	eck (	only	one)	

1 ☐ Yes 2 ☐ No

25. Was case referred to medical			
examiner? 1 ☐ Yes 2 💢 No	Hospital: 1x Inpatient	2 ER/Outpatient	3□
27 Manner of Death	280 Date of Injune	20h Time of	

(Month, Dey Year)

DOA 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Neturel

2 ☐ Accident

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier

5 Pending

investigetion

6 Could not be

MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

RESOOI

29d. Date signed (Month, Dey, Yeer)

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

, 3001 HARBOR HOSPITAL CENTER, BALTIMORE SHA HANI SADERA 31. Dete filed (Month, Day, Year)

Registrar



**ORIGINAL** 

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

or Attanding Physician: The law requires that the death certificate be executed ed by the attanding physician and datached for use as the burial-tran After this nours after death.

neral Director: After this filled in by the funeral d

To the Hospital within 24 hours a To the Funeral Completely filled

State

**DHMH 16 Rev 6/95** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day th Year **Physician** 1115 OM SHORTER 2005 May 6 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) North AnnArunde Mariner trundel Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 M Yrs. 214-01-136 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-1 show other traumatic avent, It's Medical Examiner must be nutified at 1 ☐ Yes 2 No Completed by Funeral Director MARYLAND ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Items 23a ITAL 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced BLACK "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) EACHER BALTO CITY PUBLIC XHOWS YRS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 shoutd be TURNER ဂ THOMAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 Is any injury or other trains once. Pages 1 and 2 ment of Health SAMUEL JONES (GRANDSON 05 ST, BALTIMORE MD 212 30
Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1. Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE NATIONAL 05-23-05 BALTIMORE <sup>4</sup> □ Donation 5 □ Other (Specify) 22. Name and Address of Facility BROWN TR. FUNERAL HOME 21. Signature of Funeral Service Licensee BALTO, M.D. 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician ro Selosus disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner heconevs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown luneral director, page 2 should Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Diractor: A 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier for Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated.

State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) MAY 2 0 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

balavanar

Oakwood Road

7845

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of I	Maryland		artment of H		nd Mental Hy	giene	005	1-7000	
			Decedent's Name (First, Middle, Last	)					2. Date of D	eath	443	3. Tirhe of Death	
	Physici /Medio		JERRY				SAFFER		MAY	19 <sup>Day</sup>	2005	2:30 A M	
	Examin		4a. Facility Name (If not institution, give	street and number	er)		4b. City, Town, or		Death	4c. 0	County of Death		
			2805 TANEY ROAD 5. Social Security Number 6. Se	. 7	Ago (la una la	an hidhdaul	BALTIMO	ORE	Hrs. D. Date of D.		N//		
	Funeral Director			M 2□ F	Age (In yrs. la 64		Months Days		Min. 8. Date of B (Month, D 05/26/	1940	9. Birth Cou	place (State or Foreign ntry)	
	D		Usual Residence of Decedent					11	00/20/	13 10			
	arylar ehow	-	10a. State 10b. County			, Town or Lo	ecation					10d. Inside City Limits 1, Yes 2 No	
	the M	ectc	MD 10e, Street and Number	N/A	BALT	TIMORE	10f. Zip Code			10a Citia	en of What Cou	Χ	
	with Se or	Funeral Director	2805 TANEY ROAD				21209					nu y :	
	death ms 2%	nera	11. Marital Status	12. Was Decede	nt Ever in U.S		Was Decedent of Hi	spanic Origin	? (Specify Yes or N		4. Race - Ameri		
9	after or Ite	Fur	1 ☐ Never Married 2 🕅 Married	Armed Force 1 Tes 2 If Yes, Give	S? No	1	if Yes, specify Cuba: 1 ☐ Yes 2 █ No	n, Mexican, F Specify:	derto Hican, etc.)		Black, White, Specify:	etc. VHITE	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ither than "naturel", or ttems 23e or 28e-f ehow ont, the Medical Evertiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Date	s:								
5	in 72 n "nai	Completed	15. Decedent's Edu (Specify only highest grad	le completed)		(Give	dent's Usual Occupa kind of work done o DO NOT use retired,	lurina most o	f working	16D. KIN	d of Business/In	austry	
212	d with giene.	omo	Elementary/Secondary (0-12)	College (1-4	or 5+)	PSYC	HOLOGIST			CLINI	CAL PSY	CHOLOGY	
	be file Ital Hy Id othe event,	Be C	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle	, Maiden S	Sumame)		
Maryland	should the ord Ment	ပ	HYMAN			SAF	T.	JESS				PLISS	
Mai	d 2 sh th and 17 is n treun	13	19a. Informant's Name/Relationship (T)						or Rural Route Numb .TIMORE,M			Code)	
	s 1 and f Health item 27 other tr	13	20a. Method of Disposition			ace of Dispo	sition (Name of matory or other place	1	Date Date		ation - City or To	own, State	
E	Pages nent of int: if its iry or o		1  Burial 2  Cremation 3  I		16		CEMETERY	· 1	/19/2005	CHARL	OTTSVIL	F- VA-	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or Items 23e or 28e-f ehow any injury or other treumatic event, the Medical Evarting must be notified at once.		21. Signature of up ral Service Licens	600	- Indian de	22	. Name and Addres	s of Facility	SOL LEVIN	SON &	BROS.,	INC.	
_	895 29		/and			IN ROAD -		VILLE,	MD 21208				
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	Pnysician / /Medical		Immediate Cause (Final disease or of ndition resulting in death)				r Lym	-	G months				
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	ecuted ind transi	Examiner	Cause (Disease or injury	с.									
8760,	cate be executed physician and the burial-transit	al Ex	resulting in death) cast	Due to (or	as a consequ	ence of):							
687	ficate physics the	edical		d.									
Box	death certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor			Totania standaru			23	3d. Date of delive	ery	
.0	that the death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		2 Fetal at time of de		Ectopic pregnancy Other (specify)			10	Month	Day Year	
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ds,	es gr	by	Part II. Other significant conditions co	nthbuting to deat	1 but not resu	iting in the u	nderlying cause give	n in Parti.		Yes 2	0	ne cause of death?	
200	w requir been si should	letec							24a. Was			psy findings available	
Vital Record	The lav	Completed							auto	psy prmed?	prior to co death?	mpletion of cause of	
ţ		a)	25. Was case referred to medical					26. Place of	1 ☐ Yes  Death (Check only	2 No	1 🗆 Yes	2L N0	
<u>_</u>	hysicien: nis certific I director,	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa	atient 2 E	ER/Outpatier	t 3 DOA	er: 4 🗆 Nursi	ng Home 5 Res	dence 6	Other (Specif	y)	
n of	d <b>ing Ph</b> h. After thi funeral		27. Manner of De th 1 Alatural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	Work	:?	28d. escribe	how injury	occurred		
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O	al or Attend after death Director:	Certification;	4 Homicide determined	building,	etc. (Specify	)	eer, ractory, onice			wn, State)	Tramber of Train	in Hoote Number,	
	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certifica completely filled in by the funeral director, to		29a. Certifier (Check only Medical Exam	sician: To the be	st of my knov	vledge, death	occurred at the tim	e, date and	place, and due to the occurred at the time.	cause(s) a	nd manner as s	tated.	
	the H hin 24 the F mplete	Medical	one)	and manner	stated.	OH and/or in			occurred at the time.				
	To To	-	29b. Signature and title of certifier	JAM C	alien	/	29c. License		2.0		signed (Month,	—	
,	1		30. Name and address of person who c	ompleted cause of	f death (Item	23a) (Tune	Print)	- / /	70		/ / / / - /		
	70		GARY COLLEY, MI	6569	1	CHAR	es sto	1/8	30 Artimo	KI	W Z	204	
	Sta		31. Date filed (Month, Day, Year)	2. Regi	strar's Signat	ure fac	K)					7	
	Registr	ar	MAY 2 0 2005	AST NOT	J 78"	19							

			1 - State of Maryland / Department of Maryland	artment of Health and M rtificate of Death	R	eg. No. UU5	17093
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Deal Month	th Day Year	3. Time of Death
	/Medic		Amie Dee Thornton		May 18	2005	3:15a. M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Manor Care-Roland	Baltimore If Under 1 Year   If Under 24 Hrs.	0.000	N/A	
	Funeral Director		5. Social Security Number 431-01-6112  6. Sex 1 M 2 F 89  Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, 6 12	Year) 9. Birth Cou 1915 Arl	place (State or Foreign ntry) Kansas
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Le	ocation			10d. Inside City Limits
	Mary f sh	jo	MD N/A Baltir	nore			1 XYes 2 ☐ No
	28a	rec	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Cou	intry?
	3a o	by Funeral Director	5220 York Road Apt. 8A	21212		USA	
	deati	ner	11 Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri	
9	after or fte	Fu.	1 Never Married 2 Married 1 Yes 2XXNo	1  Yes 2 No Specify:	rican, etc.)	Black, White	, etc.
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Ž	alth a alth a 27 is		Cathryn Moore-friend 1100	Pennsylvania Ave.	Apt. 20	Ol Baltimor	e, MD 21201
Je,	of Heritan		20a. Method of Disposition 20b. Place of Disposition cemetery, cre.	osition (Name of Ematory or other place)	Date	20c. Location - City or T	own, State
Ĕ	Page nent of ant: If ary or			Memorial Park 5/21	./2005	Baltimore	Co. MD
Baltimore,	permit. Departr Importa any inj		_ 14 0 1	2. Name and Address of Facility MAR			ST
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Vita	ician: Th certificete rector, pag	Be	25. Was case referred o medical examiner?	26. Place of Death			
of	ding Ph n. After th funeral	ertification; To	1 Yes 2 No No No Note 1 Inpatient 2 ER/Outpatient 2. Set Time of Injury (Month, Day Year) 2 Accident Accident Note 1 Investigation 2 ER/Outpatient 2 ER/Outpat	nt 3 DOA Nursing Ho		nce 6 Other (Speci ow injury occurred	(y)
Division	i Site	O	3 ☐ Suicide 6 ☐ Could nut be detained 28e. Place of Injury - At home, farm, st building, etc. (Specify)	,,	City or Towr		
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurr	ed at the time, da	ate and place, and due t	o the cause(s)
	To Cor		29b. Signature and title of certifity	29c. License number		9d. Date signed (Month, 5719/0)	Day, rear)
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	Sta Registr	_	31. Date filed (Month, Day, Year) MAY 2 0 2005	Le company de la			

Division of Vital Becords P.O. Box 68760

				Please	Type or Prin						•	9	
			For State Registrer		State of IVI	aryland		artment of rtificate of		th and Menta ath		ne No.2 0 0 5	17001
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· /N	ledic amin	al	ANNA MAE  4a. Facility Name (If not ins					4b. City, Town,	or Locat		5	4c. County of De	9
. EX	allilli	ĢΙ	G00D 51	THAR.	ETAN HE	OSPIT	AL	BAL	TI	MORE		NI	A
. Fun Direc			5. Social Security Number 213-16-5022	6. Se	7. Ag	e ( <i>In yr</i> s. las	ot birthday) Yrs.	Months Days			te of Birth onth, Day, Ye	ear)	irthplace (State or Foreign Country)
and			Usual Residence of Deced	lent County			Town or Lo	cation				72.0	10d. Inside City Limits
Maryl	lied a	tor	MD	N/A			ltimo						1 XYes 2 No
death with the Maryland ms 23a or 28a-f show	De Do	Director	10e. Street and Number					10f. Zip Code	000		10g.	Citizen of What C	Country?
death v	Cicinst	Funeral	3918 South	iern Av	12. Was Decedent		. 13.1		L206 Hispanio	o Origin? (Specify Y kican, Puerto Rican,	es or No-	USA 14. Race - Arr	nerican fndian,
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aryland should be file ind Mental Hy s markad oth	atic ev	To B		Price						Sylvia		Jones	
C1 (0 =	traum		19a. Informant's Name/Re James Childs		ype, Print)					umber or Rural Rout Upper Ma:			. Zip Code) 0774
or t and of Health Itam 27	other		20a. Method of Disposition			20b. Plac	ce of Dispo	sition (Name of natory or other pla		Date		Location - City of	
Dallillor Dermit. Pages Department of I	jury or		1 □ Burial 2 ♀ Crem `4 □ Donation 5 □ Of	ther (Specify)	)	1	enmou	nt Crema	atory	y 5/20/20		altimore	
Permit. Departr Importa	any in		21. Signature of Funeral S	ervice Licens	9 117		22	Name and Addr	ress of Fa Vorth	MARCH I	FUNERAL	L HOME-E	AST 21202
P	· ·		23a. Part1. Enter the dises shock, or heart failure	ase, or comp	lications that caused	the death.						ore, up	Approximate Interval Between
Physic /Medi			Immediate Cause (Final disease or condition resulting in death)	_	a. RONT	INE		EMORRI	HA6	E			Onset and Death
Exami					Due to (or as	a conseque	nce of):	onl					
/ 'R	sit	iner	Sequentially list conditions tany, leading to immodal cause. Enter Underlying Cause (Disease or injury	1	D. Sua to (or as	а фирменция	nes of):						
be executed ician and	burial-transit	Examiner	that initiated events resulting in death) Last		c. Due to (or as	a conseque	nce of):						
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hat the	Jetache	Phys	9 ☐ Unknowh Part II. Other significant c			ut not resulti	ing in the u	nderlying cause a	wen in P	art l 2°	Re Did tohac	Co use contribute	to the cause of death?
w requires to been signer	ed blu	d by	END STA	6 E	RENAL	_	ISE			aiti.	1 Tyes		Probably 4 Unknown
law rec	2 shot	Completed		* *						24	la. Was an autopsy	24b. Were a	autopsy findings available
The The Cate h	r, page									1[	performed Yes 2	? death? No 1 ☐ Ye	completion of cause of
vician: /sician: s certifica	directo	o Be	25. Was case referred to n examiner?  1 Yes 2 No	-	Hospital:	ent 2∏EF	R/Outpatien	t 3 DOA Ot	thor	lace of Death (Checonomics)  Nursing Home 5		6 □Other (Sn	ecity)
ding Phy th: After thi	ineral	On; T	27. Manner of Death	Pending	28a. Date of Inju (Month, Day		8b. Time of Injury	28c. Inju				njury occurred	<i>6011y</i> )
Wittendii death. ctor; A	y the fu	ficat	2 Accident 3 Suicide 6 □	investigation Could not be determined	28e. Place of Inju	urv - At hom	e. farm. str		Yes 2		cation (Street	t and Number or F	Rural Route Number,
tal or /	d ri be	Certification:	4  Homicide	datammad	building, et	c. (Specify)				Cit	ty or Tòwn, Si	tate)	
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funaral Director: After this certificate has been signed by the attending phys	etely fill	edical	29a. Certifier 1 Ce (Check only one) 2 Me	ertifying Phy edical Exami	sician: To the best iner: On the basis of and manner sta	t examinatio	edge, death n and/or inv	occurred at the treating of the treating of the treating at the treating of th	time, date opinion,	e and place, and du death occurred at th	e to the cause ne time, date	e(s) and manner a and place, and du	as stated. se to the cause(s)
To the Within	comp	Me	29b. Signature and title of	certifier	ARINIANI		MD	29c. Licen				Date signed (Mon	
			1400	A	BOUGER	(o.L			tS	000	0	5,17,5	2005
9	/			MAR.	ompleted cause of d	eath (Item 2	3a) (Турв, <b>А</b> L	· HARV	UAN	U ABOU	6CR	6I M	Δ.
Re	Sta gistra		31. Date filed (Month, Day,		32. Registra								
110	Si-Sili		min N	2 2000	THE STATE OF THE S								

amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Edith Vivian Turner 2 Date of Death 3. Time of Death Month **Physician** 208 7,200 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number 4c. County of Death Examiner saltimore Mary land
5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 6. Sex Birthplace (State or Foreign Country) Months Days Hours Min 217-20-1114 1 ☐ M 2 🕽 F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show injury or other traumetic avent, the Medical Examinations Legislified at 1 Yes 2 □ No Director -more 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? "netural", or Items 23s by Funeral 14. Race - American Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian Armed Forces?

1 Yes 2 X

If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 Specify: Specify: Black Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "net any injury or other traumetic avent, the Medica once. Elementary/Secondary (0-12) College (1-4or 5+) 10 other's Name (First, Middle, Last) Be neorge e/Relationship (Type, 20b. Place of Disposition cemetery, crematory 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Randallstown, mD 23a. Part 1. Siter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Keratosis Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner brillation To the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit Jak Due to (or as a consequence of): Box 68760 Physician/Medical the as attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Įõ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9□ Unknown ģ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 s has certificate 1 Yes 2 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manger of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Atter 1 ZNatural 2 ☐ Accident 5 Pending investigation Injury 1 🗌 Yes 2 No s after death in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5/17/05 completed cause of death (Item 23a) (Type, Print) Jabrook m.D. 31. Date filed (Most 32 Registrar's Signature State 2005 Registrar

			State of Maryland / De State of Maryland / De State of FH, G843, 5/26	partment of Health and Mertificate of Death	lental Hygid	ene () () 5 g. No.	7096
	Physici		1. Decedent's Name (First, Middle, Last)  Vaughn Christian Thurman	-	2. Date of Death Month	10 2005	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 4375 Baughman Mill Rd.	4b. City, Town, or Location of Death Lineboro		4c. County of Death Carroll	
	Funeral Director		5. Social Security Number 6. Sex, 124-34-5101 124 20 F 69 Yrs	Months Days Hours Min	8. Date of Birth Month, Day, March	9. Birthp	ace (State or Foreign
	ryland how		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of			11	Od. Inside City Limits
	the Ma	Director	Maryland Carroll 1  10e. Street and Number	ineboro	10	g. Citizen of What Coun	1 Tes 2 No
	ath with	ral Di	4375 Baughman Mill Rd.	21102		U.S.A.	
980	d within 72 hours after death with the Maryland jiene. r then "naturel" or Items 23e or 28e-f show the Medical Evac free fourt be redified at	by Funeral	11. Marital Status  1 □ Never Married 2 △ Married  1 □ Never Married 2 △ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Amped Forces?  1 □ Yes 2 □ No  If Yes, Give  Year or Dates:	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 Yes 2 T.No Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, of Specify: White	etc.
15-0	_ 3 33	leted	(Specify only highest grade completed) (G	ecedent's Usual Occupation live kind of work done during most of worki e. DO NOT use retired)	ing 10	6b. Kind of Business/Inc	lustry
21215-0036	e filed within al Hygiene. other then "	Completed	Flementary/Secondary (0.12) College (1.4or 5.)		alyst	Titan Cor	p.
and	O 12 O ●	Be	17. Father's Name (First, Middle, Last) Charles Lincoln Christian Thurman	18. Mother's Name Gertru	de Sterl		
Maryland	d 2 shoth and the and the modern treum	To		ailing Address (Street and Number or Rura 75 Baughman Mill Rd.	d Route Number, (	City or Town, State, Zip	
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other once.		20a. Mathod of Disposition 20b. Place of D		Date 20	Oc. Location - City or To	wn, State
Balti	permit. Page Department o Importent: If eny injury or once.		21. Signature of Funeral Service Licensee	22 Name and Address of English		Md. 21102	
68760,	Ifficate be executed Wedical By physician and as the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Extra Uncertainty Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	luce.			Onset and Death
.O. Box (	death cer e attendir d for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliver Month	y Day Year
<u>a</u>	w requires that the been signed by the should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		cco use contribute to the	
I Records,	The law ate has b page 2 sl	Completed	Conty Arthropolly.		24a. Was an autopsy performe	prior to con	sy findings available apletion of cause of
Vital	sicien: certific rector,	o Be (	25. Was case referred to fiedical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	26. Place of Death			
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Division	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/o	eath occurred at the time, date and place, a rinvestigation, in my opinion, death occurre	and due to the cau ed at the time, date	se(s) and manner as sta e and place, and due to	ated. the cause(s)
	To th To th comp	Me	29b. Signature and title of courter	29c. License number	290	d. Date signed (Month, D	Day, Year)
•	$\sigma_i$		30. Name and address of person who completed cause of death (Item 23a) (Ty			-/4/65	
	\		31. Date filed (Month, Day, Year) 32. Degistrar's Signature	Black Rock Rock 1	Ham Batco	(4, 4	21074
	Sta Registr		MAY 2 0 2005	foods			

			For State Registrar	State	of Mar	yland /		artment of rtificate o		and Me		giene Reg. No.	05	17097
	K. 1		Decedent's Name (First, Midd	lle, Last)						1	2. Date of Dea	ath		3. Time of Death
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. 90	/Medic Examin	_	4a. Facility Name (If not institution	n, give street and	number)			4b. City, Town		of Death	1110-4	-	unty of Death	
5	LAdimii	Ç   Ş	4930 Eastwood	Court				Elli	.cott C	itv		НС	ward	
	Funeral		5. Social Security Number	6. Sex		'In yrs. last	birthday)		ar If Under		8. Date of Birt (Month, Da	h V Yearl	9. Birth	place (State or Foreign intry)
31.	Director		214-66-1239	1\\ XM 2□	F	50	Yrs.	Worth's Day	S Hours		AUG. 22	2, 195	4 Ma	ryland
	р.		Usual Residence of Decedent			Oc. City, To					•			10d. Inside City Limits
	anyla shov	_	MD Howa			Ellic								1 ☐ Yes XX No
	Ba-f	Director		<u> </u>								10- 04	-6 14 5	
	with t		10e. Street and Number	~ .				10f. Zip Code				10g. Citizen		nury ?
	s 23	Funeral	4930 Eastwood		Decedent Ev	er in II S	12		.043	gin? (Spec	ify Yes or No.	US	Race - Amer	ican Indian
	itam	inne	11. Marital Status 1 ☐ Never Married 2 ☑ Ma	Amed	d Forces? es 2 X No		13.	Was Decedent of If Yes, specify C	uban, Mexicar	n, Puerto R	lican, etc.)	13.1	Black, White	
36	irs af	by F	3 ☐ Widowed 4 ☐ Divorce	If Yes	, Give or Dates:			1 ☐ Yes 2 💢 N	lo Specify:			Spe	ecity: W	nite
ŏ	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or tlams 23s. or 28s-f show ant, the Medical Examble from the notified at			nt's Education		10		dent's Usual Occ				16b. Kind o	of Business/I	ndustry
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9	be filed within 72 hours after death with the Marylar at litylene.  delitylene.  de	Be (	17. Father's Name (First, Middle	, Last)					18. Mothe	er's Name	(First, Middle,	Maiden Sun	name)	
<u>Ja</u>		To f	John Tutko, J	r.					Anna	Jani	.k		.,	
Maryland 21215-0036	s 1 and 2 should be filed w f Health and Mental Hygiei itam 27 ls marked other ti other traumatic event, th		19a. Informant's Name/Relation	ship (Type, Print)		1	19b. Maili	ng Address (Stre	et and Numbe	er or Rural	Route Numbe	er, City or To	wn, State, Zi	p Code)
	D = C =		Audrey Tutko -	wife				Eastwoo	d Cour					21043
altimore,	of He		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation	3 □Removal fr	om State	20b. Place ceme	of Dispo etery, crei	sition (Name of matory or other p			ate .	20c. Location	on - City or T	own, State
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at	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other ance.		21. Signature of Funetal Service	Licensee				2. Name and Ad			ral Ho	ma AMa:	adowri	dgeMP, Inc.
<u> </u>	20 5 2		23a. Part1. Enter the disease, o				7:	250 Wash	ington	Blvd	l., Elk	ridge,	MD	21075
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Вох	Attanding Physician: The law requires that the death certific ir death. actor: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as by the funeral director.	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant		, outcome of							23d.	Date of deliv	rery
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0	s that ned b	by P	Part II. Other significant condit	ions contributing	to death but	not resultin	ig in the u	nderlying cause	given in Part I		23e. Did to	obacco use c	contribute to	the cause of death?
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0	g Ph er thi	n: T	27. Manner of Death	28a. D	ate of Injury Month, Day	(Year) 28	b. Time o	f 28c. lr	njury at Vork?	2	8d. Describe h	now injury oc	curred	
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	To tha Hospital or Attanding Phwithin 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	edical	(Check only 2 Medica	ing Physician: To I Examiner: On th	ne basis of e	xamination								
	To tha b within 2 To tha 3 complet	Med	one) 29b. Signature and title of certif		nanner state	ed.		29c. Lice	ense number			29d. Date sig	gned (Month	Day, Year)
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		Please	State of Mar							_	· ·	
		T = For State Registrar	State of Mai	•	•	te of Deati			Reg. No.	200	5	1098
		Decedent's Name (First, Middle, Last	)					2. Date of De		Yee		of Death
Physic /Med		Eleanor	Darda	Tasker			1	Month May	18,		5 10:4	43A. <sup>™</sup>
Exam		4a. Facility Name (If not institution, give	street and number)			, Town, or Location				County of D		
		Ivy Hall Nursi		4		dle Riv	- · · · ·	0.010:-		alti		as Faucian
Funera		5. Social Security Number 6. Se	M 2 TF	(In yrs. last birth	Months		Min.	8. Date of Bir (Month, Da Jan 17	y, Year)		Birthplace (State Country) arylan	
Directo		214-22-0555 Usuel Residence of Decedent		30 "				Jani/	, 192	J 1116		
yland		10a. State 10b. County	i	10c. City, Town							10d. Inside	City Limits s 2 🖾 No
e Ma	ctor	Md. Balti	more	Ess								2 Z X 140
vith th	Funeral Director	10e. Street and Number			10f. Z	ip Code	2.1		10g. Citiz	zen of What	Country?	
eath v	eral	500 S. Marlyn	Avenue 12. Was Decedent Ev	er in U.S.	13. Was Dec	2122		ify Yes or No	o- '	USA 14. Race - A	mencan Indian,	
riten iner	Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2√ No If Yes, Give			edent of Hispanic C ecify Cuban, Mexic		tican, etc.)			hite, etc.	
ified within 72 hours after death with the Maryland Hygiene.  Hygiene. and article of tems 23s or 28s-f show only the Wedles Examine must be notified at	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 L Yes	2 No Specia	Ty:			Specify:	White	
72 hc	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. C	ecedent's Us Give kind of w	ual Occupation work done during me use retired)	ost of workin	g	16b. Kir	nd of Busine	ss/Industry	
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should be nd Mental marked o	To Be	Joseph Darda				Ar	ngeli	na Ja	sina	1		
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politimone, interpretable 2 (2.1.2.1.2.000) permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar matal be notified at		Edward Darda (	brother)			ugh St.						
of He of He of He		20a. Method of Disposition  1 Burial 2 Cremation 3 1	Removal Irom State	20b. Place of Cometery,				ete		011111	or Town, State	
Deficiency  Permit. Pages Department of P  mportant: If ite iny Injury or of		`4 □Donation 5 □ Other (Specify,	)	Holy 1	Rosar	y Cem.	5/21				re, Md	
Dermit. Departr Import		21. Signature of Funeral Service Licens	1 4 4 0			and Address of Fac Dundall						
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	dications that caused the	he death. Do no						,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Approxim	ate
ni state		shock, or heart failure. List only of	ne cause on each line	ocho	mil-	Condi	any	zhak	hy		Interval B Onset an	d Death Known
Physicia /Medica		disease or condition resulting in death)	a. Due to (or as a	consequence of		<u></u>	0	J - id			Car	1200
Examine	r	A CONTRACTOR OF THE CONTRACTOR	b									
. (7) =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of	):							
scute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to for an a	consequence of	١,							
te be executed ysician and e burial-transit	sal Ex	10001119 111 0001117 00011	Due to (or as a	consequence or	).							
oo oo oo oo oo oo oo oo oo oo oo oo oo			d									
ath certification of the use a	N/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	fpregnancy	0.75-1	.000000000			2	23d. Date of	delivery	
death death e atte	cla	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown		3 ☐ Ectopic 5 ☐ Other (					Month	Day	Year
by the	Physician/Medi	9 Unknown						100 511				
The COIGS, P.O. BOX 001  The law requires that the death certificate are has been signed by the attending physpage 2 should be detached for use as the	<u>م</u>	Part II. Other significant conditions co	entributing to death but	not resulting in	- /	cause given in Pa	la Val			se contribut ∃No 3□	e to the cause of	Unknown
ord requir een s	Completed	11-11	That			( // ( )	Man all			T		
VICAL NECOLOS, ician: The law requires to entificate has been signe ector, page 2 should be	mple	HIM	Tran	m a				24a. Was		24b. Were prior death	autopsy linding to completion of n?	cause of
Cal T Th T: Th licate		of War and Manual Variable				00.00			2 🔀 No	10	Yes 2∑No	
VICAL NEC sician: The law s certificate has b lirector, page 2 s	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2√2√40	Hospital: 1 ☐ Inpatien	t 2 ER/Out	nationt 3 🗆	Othor	ace of Death Nursing Hom			S Other /5	Specify)	
Phy Prthis eral d	I	_ XX	28a. Date of Injury (Month, Day			28c. Injury at Work?		8d. Describe			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
nding ath. r: Ate	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	1	1007	М	1 ☐ Yes 2	□No					
JIVISION i or Attending after death. Director: After	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	ry - At home, fare (Specify)	m, street, fact	ory, office	2	8f. Location City or To	(Street an wn, State	d Number o	Rural Route N	ımber,
urs aff	Cer									~		
DIVISION OF VICAL IN To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of niner: On the basis of and manner state	examination and	death occurre or investigati	ed at the time, date on, in my opinion, d	and place, a death occurre	ind due to the ed at the time	, date and	place, and	r as stated. due to the cause	a(s)
o the ithin 2 o the omple	Mec	29b. Signature and title of certifier	und mannor state		- 2	29c. License numbe	er		29d. Dat	e signed (M	onth, Day, Year	)
F ≯ F 8		M-1	D ·			D 3875	4		May	19,	2005	
. 4		30. Name and address of person who	completed cause of de	ath (Item 23a) (1	Type, Print)							
10	-	Malila F. Wasee			stern	Blvd.	Balti	more,	Maı	rylan	d 2122	1
	State strar	31. Date liled (Month, Day, Year)  MAY 2. 0 20	32. Begištrai	rs Signature	Locali	Con.						

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	casc	-		nd / Depa		Health and M	lental Hyg	•	) 5	17099		
			Decedent's Name (First, M.)	liddle. Las				inouto or	Doain	2. Date of Dea			3. Time of Death		
	Physic		Marian Amelia							Month	Day	Year	6:50 PM		
	∘ /Medi Examir		4a. Facility Name (If not instit	ution, give	street and nun	nber)		4b. City, Town,	or Location of Death		4c. County		6,001		
	Exami		Franklin Si	0.10	re Has	espital		Rosed	ale		Balti	กายเ	,_		
	Funeral		<ol><li>Social Security Number</li></ol>	6. S	өх	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day	Voar		lace (State or Foreign try)		
	Director		217 03 8180	1	☐ M 2 <b>∏</b> F	96	Yrs.	Worldis Days	Hours Min.	August	3,1908	Mary			
	pu »		Usual Residence of Deceden  10a. State 10b. Cou			10c Cit	ty. Town or Lo	nation				1/	0d. Inside City Limits		
	laryla sho	J.		timo:	~		ddle R					, ,	1 ☐ Yes 2½ No		
	the A	ect	Maryland Bal	CTINO		1711	aute n	10f. Zip Code			10g. Citizen of	What Count			
	hours after death with the Maryland tural; or Itams 23a or 28a-f show al Exc. ither out be nutilled at	Funeral Director	945 Bowleys Q	uarte	ers Road	Ē		212	20		USZ				
	Jeath	era	11. Marital Status		12. Was Dece Amed For		.S. 13.	Was Decedent of I	Hispanic Origin? (Sp	ecify Yes or No-	14. Rad	e - America	an Indian,		
(O	or Itan	Fun	1 Never Married 2	Married	1 Tyes	2 X No				Rican, etc.)		ck, White, e			
93	ral', o	by	3 ₩Widowed 4 Divor	rced	If Yes, Giv Year or Da	e ates:		1 ☐ Yes 2 ☒ No	Specify:		Specif	y: Whi	te		
20	72 hc	Completed	15. Dece (Specify only hi	edent's Ed	lucation de completed)		16a. Dece	dent's Usual Occu	pation during most of work ed)	ina	16b. Kind of B	usiness/Ind	lustry		
27.5	within 72 ane. than "na	npl	Elementary/Secondary (0-1		College (1	-4or 5+)			nd)		Or.m. II.	amo.			
25/2	led w tygien har ti		12 17. Father's Name (First, Mid	Idla I anth			П	ousewife	10 Mathada Nam	- /First Adiddle	Own Ho				
Z. 2	htal Hed ot	Be	17. Father's Name (First, Mid	ule, Lasi)			U	nk.	18. Mother's Name	de Buckm		ne)			
$\lesssim \mathcal{M}_{\alpha r i \alpha  ilde{lpha}}$ Marvland 21215-0036	should nd Men marke	10	19a. Informant's Name/Relat	ionshin (7	Tyne Print)		19h Mailir	no Address /Stree	t and Number or Run			State Zin	Codel		
$\sim 5$	nd 2 s lith an 27 is		Gary L. Voris					-	uarters Ro						
orie.	Hear Ham Ham other		20a. Method of Disposition	-		20b. F	Place of Dispo	esition (Name of matory or other pla	una)	Date	20c. Location	City or Tov	wn, State		
100	Pages nent of int: If it		1 ⊠Burial 2 □ Cremat `4 □ Donation 5 □ Othe	ion 3. ☐ er <i>(Specif</i> y	Removal from S				rdens 5/2	3/2005	Baltimo	ore. M	Marvland		
Vori Baltimore.	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Health and		21. Signature of Funeral Serv			D			ess of Facility ki Funera						
ŭ	Depared Important any ir		John W.	Bu	rkous	ke	1	407 old	ki funera. Eastern Av	venue Es	sex, Mo	1. 212	221		
			23a. Part1. Enter the disease shock, or heart failure.	e, or comp	plications that ca	aused the deat	h. Do not ent	er the mode of dy	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between		
	Pnysician		Immediate Cause (Final disease or condition	ŕ	-1	irati	1.4	neume					Onset and Death		
	/Medical		resulting in death)			or as a conseq			11101						
- 0	Examiner		Sequentially list conditions,	- 1	b										
1	bed isi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	4	Due to (	or as a conseq	uence of):								
V	ate be executed sysician and he burial-transit	хап	Cause (Disease or Injury that initiated events c. resulting in death) Last Due to (or as a consequence of):												
760.	be e. ician buria	calE													
687	ficate physis the				. d.										
Box	that the death certifical ed by the attending phydelached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	t	23c. If yes, out						23d. Da	te of deliver	ry		
ă	death e atte d for	icia	in the past 12 months?		4 Pregn	irth 2 🗌 Feta ant all time of d		]Ectopic pregnanc ] Other (specify) _	у		Mo	nth	Day Year		
0.0	t the by the lache	hys	9 Unknown		9□ Unkno	wn									
	The law requires that the death certification has been signed by the attending phage 2 should be detached for use as it	by P	Part II. Other significant con	ditions o	ontributing to de	eath but not res	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	bacco use cont	ribute to the	e cause of death?		
rd	w require been si should b	pel			_		_			1 🗆 Y	es 2 🗌 No	3 Proba	ably 4 Unknown		
e C	law r as be	Completed								24a. Was a autops	SV	prior to com	sy findings available		
<u>~</u>		Con								perfor	med?/	death?			
/ita	Physician: r this certificanal director,	Be (	25. Was case referred to me examiner?	100					26. Place of Deat						
	hysi this c	은	1 ☐ Yes 2 ☐ No				ER/Outpatier		ner: 4 Nursing Ho				)		
n o	ding Phys	iio	27. Manner of Death 1 Natural 5 □ Pe	ending		of Injury h, Day Year)	28b. Time of Injury	Wo	rk?	28d. Describe h	ow injury occur	red			
Sic	death.	cat	3 ☐ Suicide 6 ☐ Co	estigation ould not be		of Injuny - At he	omo form et	M 1 =	]Yes 2□No	28f. Location (S	troot and Numb	or or Puml	Poute Number		
Division of Vital Becords.	To the Hospital or Attending Physician: within 24 hours after death within 24 hours after death To the Funaral Director. After this certific completely filled in by the funeral director.	Certification:	4 Homicide de	termined	buildir	ng, etc. (Specif	(y)	eet, ractory, office		City or Town		or or ribrar	rioute ramber,		
	spital tours naral filled		29a. Certifier 1 Cert	ifying Ph	ysician: To the	best of my kno	wiedge, deatl	occurred at the ti	me, date and place,	and due to the c	ause(s) and ma	inner as sta	ated.		
	a Ho a Fu	Medical	(Check only 2 Med one)	ical Exan	ninar: On the ba and mann	asis of examina	ition and/or in	vestigation, in my	opinion, death occurr	ed at the time, d	ate and place,	and due to	the cause(s)		
	vithir To th	Me	29b. Signature and title of ce	rtifier				29c. Licen			9d. Date signe		Day, Year)		
			A	you	6 20	MD		Di	006133	7	5/19	105			
	4		30. Name and address of per	rson who	completed caus	e of death liten									
			21.	au	1 Ah	brm.	9000 F	ranklin	Square	prive, B	altimo	ce.M	D 21237		
	Sta Regist	21	31. Date filed (Month, Day, Y		- 11	egistrar's Signa	ature	2000							
	negist	aı	mA) i	NUL	OOJ G	SUR !	5 65	E-47							

			1 - For State Registrar	State of	Maryland	•	artmen rtificate					giene Reg. No2	005	171	00
	Physici	an	1. Decedent's Name (First, Mid-	dle, Last)							<ol><li>Date of De Month</li></ol>	Day	Year	3. Time of D	)eath
	/Medic	al	John Whaley  4a. Facility Name (If not instituti	on give street and num	her)		4h City	Town or	Location of	of Death	May	17,	2005 unty of Death	3:45	M
	Examir	er	St. Elizabeth					timo		or Doain		40. 00	anty of Dogin		
	Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs. I		If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th v. Year)	9. Birthp	place (State or I	Foreign
,	Director		298-10-8573 -A	1 M 2 □ F	89	Yrs.	Montalo	Duyo	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		SEP. 25	, 191	_	Virgir	
	land		Usual Residence of Decedent  10a. State 10b. Coun	ty	10c. City	, Town or Lo	cation						1	0d. Inside City	Limits
	Mary I sh	tor	MD Howa	ırd	E1	kridge	9							1 Tes 2	²¥No
	3a or 288	I Direc	10e. Street and Number 6406 Harthorn	Avenue			10f. Zip	Code 1075				10g. Citizer	of What Coul	ntry?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23a or 28a-f show amy injury or other treumatic event. If a Madical Examination that he intiffied at Once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Ma 3 □ Widowed 4 □ Divorce	12. Was Deced Armed Ford 1 XI Yes 2 If Yes, Give year or Da	<sup>2 □ No</sup> Nav	Y 13.	Was Deced If Yes, spec		spanic Ori n, Mexican Specify:		ecify Yes or No Rican, etc.)		Race - Americ Black, White, ecify: Wh		
215-0036	should be filed within 72 hours aft nd Mental Hygiene. marked other then "natural", or i imatic event, II e Medical Exami	Completed I	15. Decede	ent's Education est grade completed)		16a. Dece	dent's Usua kind of wor DO NOT us	l Occupa	ition uring mos	t of worki	ing	16b. Kind	of Business/In	dustry	
121	within ane. then '	mpl	Elementary/Secondary (0-12)	College (1-	4or 5+)		ial S					Corro	rnment		
d 21	filed Hygid Sther ent, II	e Co	17. Father's Name (First, Middle	ə, Last)		500.	IGI D	CCUL			(First, Middle,				
Maryland	Mental Mental arked o	To Be	Claude Whale	У							'owler				
	alth and 27 is mu		19a. Informant's Name/Relation Norma Sue Whale								Name Number			_	
Baltimore,	Pages 1 and of He		20a. Method of Disposition  1 X Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other		tate ce	lace of Dispo emetery, crer adowric	natory or o	ther place	1		1/2005		ion - City or To		
Baltii	Departm Departm Importer any injue		21. Signature of Funer I Service	e Licensee	181	Ga:	Name and	d Addres Kau:	s of Facilit Eman	y Fune	ral Hon	ne@Me	adowrio	ige MP, I	[nc.
	Pnysician /Medical		23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	a	used the death ch line. or as a cons	Do not ent	50 Was er the mod	shine of dying	415				MD 2	Approximate Interval Betwee Onset and De	en lath
8760,	certificate be executed admin physician and see as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (c) c. Due to (c) d.	ir as a consequ	uence of):	VK,	ICV	Inv	ar	win			24	105
P.O. Box 68	death certific e attending p ed for use as t	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		th 2 ☐ Fetal int at time of de	death 3	Ectopic pro					23d	. Date of delive	ery Day Yea	ar
	w requires that the been signed by th should be detache	by	Part II. Other significant condi	tions contributing to dea	ath but not resu	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did t		/	ne cause of dea pably 4 []Unl	
Vital Records,	has b	Completed									24a. Was autop perfo		prior to co death?	psy findings avanted in the ps	ailable ise of
/ita	ysician: Th	Be (	25. Was case referred to medic examiner?							of Death	(Check only o	one)			
of \	× 5 ₽	2	1 Yes 2 No			ER/Outpatier			411111	-	me 5 Resid			y)	
on c	ding After fune	tlon	27. Manns of Death  1 Natural 5 Pend	ding 28a. Date of (Month stigation	, Day Year)	28b. Time of Injury	M Z	8c. Injury Work	at ? ∕es 2 🔲 i		28d. Describe I	now injury of	curred		
Division	or Attending fter death. Director: Afte n by the fune	Certification;	3 Suicide 6 □ Coul	d not be 28e. Place of	of Injury - At ho g, etc. <i>(Specify</i>	me, farm, str ')					28f. Location ( City or Tox		umber or Rura	I Route Numbe	<i>∋r</i> ,
П	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical Ce	29a. Certifier 12 Certify (Check only one) 14 Certify	ring Physician: To the la al Examiner: On the bar and mann	sis of examinat	wledge, deatl	n occurred a	at the tim in my op	e, date an inion, dea	d place, a	and due to the ed at the time,	cause(s) and date and pla	d manner as since, and due to	tated. the cause(s)	
	To the within To the comple	Med	29b. Signature and litle of certif		6/	25.	290	License	number	7	19	29d. Date s	gned (Month,	Day, Year)	
	6+1		30. Name and address of person	n who completed cause	of death (Item	23a) (Type,	Print)	)	5/	bn	1. Rs //	in	RI E	Bulk	Wass
	Sta Regist		31. Date filed (Month, Day, Yea MAY 2 0		gistrar's Signat	ture	وي				(.(-	*	( /	100	7 140

			1 - For State Registrar	State of Maryla	•		f Health and I of Death		giene Reg. Na <sup>2</sup> 0 0 1	5 17101		
	Physici		1. Decedent's Name (First, Middle, Last) Dolores Clara	Wolff				2. Date of Dea Month	Day Ye	3. Time of Death		
	/Medic Examin		4a. Facility Name (If not institution, give st. Union Memorial Ho			-	n, or Location of Deat	h	4c. County of D	Death		
	Funeral Director		5. Social Security Number 6. Sex		s. last birthday) Yrs.	If Under 1 Y Months Da	ear If Under 24 Hrs lys Hours Min.	8. Date of Birth (Month, Day Sept. 15	9. 5,1917 Ma	Birthplace (State or Foreign Country) aryland		
	f ahow	or	Usual Residence of Decedent  10a. State 10b. County  MD N/A	10c. (	City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
	or 28a-1	Director	10e. Street and Number		Dartin	10f. Zip Co			10g. Citizen of What			
	r death w tams 23a	Funeral	The Market Glades	2. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent	214 of Hispanic Origin? (S Cuban, Mexican, Puer	pecify Yes or No- to Rican, etc.)	U.S.A 14. Race - A Black, V	American Indian, Vhite, etc.		
0000	hours afte	by	1 □ Never Married 2 □ Married 3 🂢 Widowed 4 □ Divorced	1 □ Yes 2 XX No If Yes, Give Year or Dates:		1 □ Yes 2 <b>X</b>			Specify:	White		
-61717	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or Items 23a or 28a-f ahow or other traumatic event, the Medical Ever it with unit to notified at	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	DO NOT use re	one during most of wo		Baltimor Electric			
yiana,	ould be filed Mental Hyg arkad othe atic evant,	To Be C	17. Father's Name (First, Middle, Last) Ferdinand Franci				Mary J	osephine				
Mar	nd 2 sho alth and 27 ia m ir traum		19a. Informant's Name/Relationship (Type Mr. Leonard J. Wol				reet and Number or Ri e Avenue B					
more,	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Place of Disponent Place of Disp	natory or other	n Cem. 5/2	Date 3/05	20c. Location - City Baltimore	or Town, State e, Maryland		
Банттог	permit. Departm Importar any inju		21. Signature of Funeral Service License		ain 22	2. Name and A	ddress of Facility L	eonard J				
8/00, *	Physician pe executed funding physician and price as the purial-Itansit	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
C. Box 6	death certing e attending nd for use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 moeths? 1	c. If yes, outcome of predictions of the second sec	etal death 3	Ectopic pregn			23d. Date of Month	delivery Day Year		
as, F.	w requires that the been signed by th should be detache		Part II. Other significant conditions conf	tributing to death but not	resulting in the u	nderlying caus	e given in Part I.			te to the cause of death?  Probably 4 Unknown		
I Kecoras	The law ate has b page 2 sl	Completed										
VITAI	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA	Other	ath (Check only on the state of the state o	ne) lence 6 Other (	Specify)		
lon of	nding Physith.	atlon: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time o		Injury at Work?		now injury occurred			
DIVISION	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Ptace of Injury - A building, etc. (Spe	t home, farm, st ecify)	reet, factory, of	fice	28f. Location (S City or Tow		r Rural Route Number,		
	e Hospi 24 hou e Funer letely fill	edical	29a. Certifier 1 To Certifying Phys (Check only one)	ician: To the best of my ter: On the basis of exam and manner stated.	knowledge, deat ination and/or in	h occurred at to vestigation, in	ne time, date and plac my opinion, death occ	e, and due to the curred at the time,	cause(s) and manne date and place, and	or as stated. due to the cause(s)		
	To the To the Complex	Me	29b. Signature and title of certifier	<u> </u>		29c. L	cense number		29d. Date signed (M	fonth, Day, Year)		
	·'n		30. Name and address of person who cou	mpleted cause of death (I	tem 23a) (Type,	Print)	11764351	+16015	May 1	1,2005		
		ate	Raycan Harris  31. Date Hied (Month, Day Ygar)	201 East 32. Registrar's Si	Univer	Sity B	nieward.	Paltimo	M, MD	31318		
	Regist		MAY 2 0 2005	De mar	7 GOB	4						

			1 - For State Registrer Amend	Item	State of Ma 4c per D	aryland c.,G8	i / Depa <b>43,<u>05</u>/</b>	rtment of l 25/05dbl tilicate of	Health and Me Death	ntal Hygier Reg. N	2005	17102		
			1. Decedent's Name (First,	Middle, Last)					2	2. Date of Death Month	ay Year	3. Time of Death		
	Physicia /Medic		CALIP WILLIAM	<b>1</b> S							8, 2005	311 pm		
	Examin		4a. Facility Name (If not inst			la e	1.1	•	or Location of Death	4	c. County of Deat			
	7			mar		10501	tal		more		Scatti	more city		
E	Funeral Director		5. Social Security Number 267 62 0795	6. Sex	M 2 F 7. Ag	e (In yrs) ia 65	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Report 1	Date of Birth (Month, Day, Yea)	r) Co	hplace (State or Foreign untry) YLAND		
	yiand		Usual Residence of Decede  10a. State 10b. Ce			10c. City	Town or Lo	cation				10d. Inside City Limits		
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	ih th or 28	Director	10e. Street and Number					10f. Zip Code		10g. (	itizen of What Co	untry?		
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pu	be filed Ital Hygi Id othar evant, I	Be (	17. Father's Name (First, Mi	ddle, Last)					18. Mother's Name (	First, Middle, Maide	an Sumame)			
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, Maryland	s 1 and 2 should Health and Mer Itam 27 Is marks othar traumatic	1 37	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1306 GOODWOOD AVE. ESSEX, MARYLAND 21221											
altimore,	0 0		20a. Method of Disposition 1 □ Burial 2 □ Crema 1 □ Donation 5 □ Other		emoval from State	ce	metery, cren	sition (Name of natory or other pla VI' CREMAT	CORY MAY 20	18.40	Location - City or			
Balti	permit. Pag Department Important: I any injury o		21 nature of Funeral Se	rvice License	7//	110		. Name and Addre	CAL			KERAL HOME		
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<u>α</u>	that the the the the the the the the the th		Part II. Other significant co	nditions con	tributing to death b	ut not resu	ting in the u	nderlying cause gi	ven in Part I.	23e. Did tobacco	use contribute to	the cause of death?		
ds	quires an sign uld be	d by								1 🗆 Yes	2 □ No 3 □ Pro	obably 4 Donknown		
of Vital Records,	The law raquate has baan page 2 shoul	Completed				24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of						
ita	ician: certifical	Be C	25. Was case referred to m	edical					26. Place of Death (					
<u></u>	ys Si	10	examiner? 1 ☐ Yes 2 ☑ No	Н	ospital: 1 Inpatie	ent 2	R/Outpatien	t 3 DOA	ner: 4 🗆 Nursing Home	5 Residence	6 ☐Other (Spec	cify)		
		:uo	27. Manner of Death 1 ☑Natural 5 ☐ F	ending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	28c. Inju Wo	ry at 28 rk?	d. Describe how in	ury occurred			
Sio	ne at	cati	2 Accident	ould not be					]Yes 2□No					
Division	al or Attending s after death. al Diractor: Afte ed in by the fune	Certification:		etermined	28e. Place of Inj building, et	ury - At hor c. <i>(Specify)</i>	ne, farm, str	eet, lactory, office	28	f. Location (Street a City or Town, Sta		ral Route Number,		
	To the Hospital or Attu within 24 hours after de To tha Funaral Diracto completely filled in by th	edical (	29a. Certifier (Check only one) Ce	rtifying Phys dicel Exemir	sicien: To the best ner: On the basis o and manner st	t examinati	rledge, death on and/or in	occurred at the tivestigation, in my	me, date and place, an opinion, death occurred	d due to the caused at the time, date a	s) and manner as nd place, and due	stated. to the cause(s)		
	To ti To ti Comp	Ň	29b. Signature and title of o	ertifier	20			29c. Licen:			ate signed (Month			
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No.") 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 9:30P (FRANK) FRANCIS Μ. WILSYNSKI Sr. MAY 14 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROCKY MOUNT ROSEDALE ROAD BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** Min. Days Hours 1 ☐ MM 2 ☐ F Months 80 220-18-6393 Director 2-22-1925 MARYLAND Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If itam 27 Is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, the Mydical Examination in the profiled at once. 10a. State 10b. County ROSEDALE BALTIMORE 1 Yes 2 No MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21237 8418 ROCKY MOUNT ROAD U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑X'es 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) POLICE OFFICER BALTIMORE COUNTY 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be WALTER WILSYNSKI WANDA (KOZLOWSKI) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8418 ROCKY MOUNT ROAD ROSEDALE, MD 21237 CATHERINE WILSYNSKI/ WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☑ Other (Specify) ENTOMEMENT CARDENS OF FAITH CEM 5-19-2005 BALTIMORE, MD 21. Signature of Funeral Prvice Lilens 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER NETASTATIC COLON Priysician 1/2 gears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ner The law requires that the death certificate be executed attending physician and for use as the burial-transit Physician/Medical Exami that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No the 9□ Unknown 9 Unknown signed by d 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 No 3 □ Probably 4 □ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 🐉 No Division of Vital Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending 12 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire Decrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Zano ma D40480 16, 2005 7-02 BELAIR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 120 FERNANDO 21236 tenno MO BALTMORE MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

		ĺ	1 - For State Registrar	State of Mar	ryland		artment rtificate			nd M		Reg. No.	GUU.	17	04
	Physici /Medic	ał	Decedent's Name (First, Middle, Last, Homer Burton Wood     Aa. Facility Name (If not institution, give	S			4h City T	Fown or	Location of	Death	2. Date of De Month May	Day 19,	Year 2005 County of Dea	6:00	5 M
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	h the Mary r 28a-f sho	irector	Maryland Baltimor	е	Mic	ddle R	iver	Code				10g. Citi	izen of What C		s 2X No
ထ္	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy righty or other traumatic event, Ite Modical Examination until to indiffice at Once.	by Funeral Director	132 Roundup Rd.  11. Marital Status  1  Never Married 2 Married	12. Was Decedent Ev Armed Forces? 1⊠Yes 2□No If Yes, Give 1.17.	)	ı		fy Cuba	spanic Orig n, Mexican, Specify:	in? (Spe Puerto F	cify Yes or No Rican, etc.)		USA  14. Race - Am Black, Whi  Specify: W	ite, etc.	
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, Maryland	and 2 shoul saith and Me n 27 ie mark ier traumati	Ţ	19a. Informant's Name/Relationship (Ty			132 1	Roundi	up R	ind Number	r or Rura			r Town, State, 1220	Zip Code)	
Baltimore,	it. Pages 1 rtment of He rtant: If iten njury or oth		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens		Ce		natory or oti	th C	emete	ry 5/	ate /21/20(		ocation - City of		'land
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8760, <	The law requires that the death certificate be executed at the death certificate be executed by Medicinal and at the attending physicien and page 2 should be detached for use as the burial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a document)  Due to (or as a document)  Due to (or as a document)	consequ	Jence of):	XL B	•	Zum Bis	gi.	-J			Onset and	h.
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Division of Vi	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ation: To B	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day)		ER/Outpatien 28b. Time of Injury		3c. Injury Work	or: 4□ Nur	sing Hom		dence (	5 □Other (Spe y occurred	ecity)	
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	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exami one)  29b. Signature and title of certifier	sician: To the best of ner: On the basis of e and manner state	examinated.	ion and/or inv	estigation,	in my op	inion, death	n piace, a h occurre	nd due to the	date and	e signed (Mon	e to the cause(	(s)
	RH		30. Name and address of person who of	T 1-1 h = 1	ath (Item	′	-	D 6	62	02		h	5/20/		
	Sta Registr		1\ 6\ B\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	32. Registrar	's Signat	ture (Jose	9110	<u> </u>	HIL	カカ	ELY	AI/6		), 21	237.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3 Tirde of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 12:11 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** REGIONAL HOSPITAL AUREL er 1 Year | If Under 24 Hrs. GEORGES 8. Date of Birth (Month, Day, 2/23/ 7. Age (In yrs. last birthday) **Funeral** 5. Social Security Number Birthplace (State or Foreign Country) Min 1 M 2 F Months Days Hours UNKNOWN **Director** MINNESOTA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahov item 27 ia marked other than "natural", or Items 23a or 28a-f ahoi othar traumatic event, Ina Medical Examinat must be notified at 1 ☐ Yes 2 ☑ ★ 6 Completed by Funeral Director PRINCE GEORGES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? NITED STATES

14. Race - American Indian,
Black, White, etc. 73 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 2 No Yes Baltimore, Maryland 21215-0036 1☐ Yes 2☐No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within in and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be DR6E ို 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 ia m any injury or othar traum once. ace of Disposition (Name of Date 20c. Location - City or Town, State LINDA ZAJACZKOWSKI/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ANATOMY GIFTS REG. 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 234. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Ineumonio /Medical Due to (or as a consequence of): Examiner Ca LCINDMO Sequentially list conditions, lany leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of); Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 hpatient Other: 1 ☐ Yes 2 X No Medical Certification; To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. D te of Injury (Month, Day Year) 27. Manner of Death 1X Natural 2 ☐ Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: / 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) MAY 2 0 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.S. AUTLA MD 5033 ANNAPOUS RD.

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SUITE # 13 PLADENSBURG, MD. 20710

Physici /Medio		Decedent's Name (First, Middent Gary Zepp	dle, Last)		erwicaie.			2. Date of Death Month May 7, 2		Year 10	ime of Death :44 PM		
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		Washington Ad  5. Social Security Number		pital . Age (In yrs. last birtho		a Park		8 Date of Birth		gomery	State or Forei		
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the M	Director	10e. Street and Number		11,40	10f. Zip Cod			100	. Citizen of	What Country?	71		
3a or	Ö	6401 Medwick	Drive			20783				USA			
be filed within 72 hours after death with the Maryland tal Hygjene. Id othar than "natural", or items 23a or 28a-f show evant, the Medical Examinating the notified at	Funeral	11. Marital Status	unk 12. Was Deced	ent Ever in U.Sunk	3. Was Decedent	of Hispanic O	rigin? (Spec	cify Yes or No-		ce - American Indi	ian,		
or ite	y Fu	1 Never Married 2 Ma	ırried 1 ☐ Yes 2 If Yes, Give	□No	1 ☐ Yes 2 🔯			tiouri, oto.,		v white			
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d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relation Washington			ailing Address (Str 7600 Car			Route Number, C Takoma					
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permit. Pages 1 ar Department of Hea Important: If itam any injury or otha					22. Name and Ac	dress of Faci	lity		_				
Depring any sany		21. Signature of Funeral ervice Licensee 655 W. Baltimore Street Baltimore, MD 21201 State Anatomy Board											
		23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that cause only one cause of each	used the death. Do not						Appro	oximate al Between		
Pnysician		Immediate Cause (Final disease or condition	(0	1 va by	An how	· 11	100	Ve		Onse	t and Death		
/Medical Examiner		resulting in death)	To to for	r as a consequence of):		N		1					
	ē	Sequentially list conditions,	b. Nue to for	r as a lons - uence of	17 44	ory l	19 74	ines S	yndu	ave			
betr	min	cause. Enter Underlying Cause (Disease or injury that initiated events  c.											
exect an and rial-tra	Examine	resulting in death) Last  Due to (or as a consequence of):											
cate be executed obly sician and the burial-transit	dlcal		d										
The law requires that the death certificate be executed ste has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Med	IF FEMALE:											
eath certific attending p	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birt	ome of pregnancy	3 Ectopic pregna					ate of delivery onth Day	Year		
it the de by the a tached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregnar 9⊟Unknow	nt at time of death vn	5 ☐ Other (specify	′)							
es that tigned by		Part   Other significant condi	tions contributing to dea	th but not resulting in th	e underlying cause	given in Part	I.	23e. Did toba	cco use con	tribute to the caus	se of death?		
quires n sigr ald be	d by	1, 2500	Mell	1 fee				1 🗆 Yes	2 🗆 No	3 ☐ Probably	4 Unknov		
faw requires t as been signe 2 should be	Completed	4-1-1-						24a. Was an	24b.	Were autopsy fin	re autopsy findings available		
The lav	mo							autopsy performs	d? A No	prior to completio death? 1 ☐ Yes 2 ☐ N			
	BeC	25. Was case referred to medic	al			26. Plac	e of Death	(Check only one)	110				
8 s	10	examiner? 1 □ Yes 2 X No	Hospital: 1	patient 2 ER/Outpa	itient 3□ DOA	Other: 4   N	lursing Hom	ne 5 ☐ Residen	ce 6 🗆 Ot	her (Specify)			
ter in										rred			
or Attanding after death. Diractor: Afte	Certification;	2 Accident inves	at and Alsom	har or Owen Bout	a Alumbar								
or At after of Dirac in by	ertif	4 Homicide deter	mined 286. Place o building	f Injury - At home, farm g, etc. <i>(Specify)</i>	, street, factory, off	ice		8f. Location (Stre City or Town,		per or nural noute	a ivanibar,		
spital ours cours naral filled		29a. Certifier Certify	ing Physician: To the b	est of my knowledge, o	eath occurred at th	e time, date a	ind place, a	nd due to the cau	se(s) and m	anner as stated.			
To the Hospital or Attanding within 24 hours after death. To tha Funara! Director: After completely filled in by the fune	Medical	(Check only 2 Medica one)	al Examiner: On the bas and manne	sis of examination and/o	r investigation, in n	ny opinion, de	ath occurre	d at the time, date	and place,	and due to the ca	ause(s)		
To the vithing To the Comp	M	29b. Signature and title of certif	ier		29c. Lic	ense number		290	l. Date signe	ed (Month, Day, Y	'ear)		
		Lucia	1		H3	607	1	5	- >	-05			
		)   MUTH =											
		30. Name and address of person	n who completed cause	of death (Item 23a) (Ty	pe Print)	7	1	)		2 - 2			

		1	For State Registrar		State o	f Marylaı		artmen rtificat			and M		Reg. No.	005	1710
Phys		1.	Decedent's Name (First, Middle Ma	e				2. Date of Dea Month May 7,	Day	Year	3. Time of Death 11:00 A <sub>M</sub>				
Exan	dical niner	48	a. Facility Name (If not institution					4b. City,	Town, or	Location of	of Death			unty of Deat	h
		ı.	13425 Point Loc	kou	t Road	, Apt.	25	Ric	lge				Sa	int Ma	ry's
Funer	al		Social Security Number	6. Sex		7. Age (In yrs				If Under	24 Hrs. Min.	8. Date of Birtl (Month, Day	Yearl	9. Birtl	hplace (State or Foreign untry)
Directo			216-19-0374	1 🗆	M 2⊠F		98 Yrs.	MOHEIS	Days	Hours	WIII I,	May 17,	1906		yland
<b>D</b>		-	sual Residence of Decedent												
rylar			Da, State 10b. County			10c. C	ity, Town or L	ocation							10d. Inside City Limits
a-fe	5	I	Maryland Saint	Mary	's	Ri	ldge								1 ☐ Yes 2 ☑ No
th th	)ire	10e. Street and Number 10f. Zip Code 10g. Citizen of What Co											untry?		
th wi	ai		13425 Point Lookou	t Ro	ad, Apt.	25		20	680_				USA	1	
72 hours after death with the Maryland 72 hours after death with the Maryland natural; or Items 23e or 28e-f ehow dical Examiner must be notified at	Funeral Director	1	1. Marital Status		12. Was Dece Amed Fo	edent Ever in U rces?	J.S. 13.	Was Deced	tent of Hi	ispanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)	14.	Race - Ame Black, White	
afte or it			1 Never Married 2 Marr	ied	1 ☐ Yes If Yes, Giv	2 🔯 No /e		1 ☐ Yes		Specify:				anife.	
Jral',	q p	_	3 X Widowed 4 ☐ Divorced	Year or D	Year or Dates:								WII	ite	
nath dies	Completed by		15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired)							of Business/	Industry				
ad within 72 hours aff giene. er then "natural", or t, the Wedical Exami	du	•	Elementary/Secondary (0-12) College (1-4or 5+)												
filed within Hygiene. other then "			8 7. Father's Name (First, Middle,	( 004)			Но	memaker	·	10 Matha	do Nam	e (First, Middle,		n Home	
be fi	Be		•											mane)	
Mat ylailu d 2 should be file tith and Mental Hy 27 Is marked oth treumatic even!	2	James Robert Graves Mary Elizabeth Long													
2 sh 2 sh 3 and 1s m		1	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Thomas D. Angle / Son  10 Beth Stacey Blvd., At. 203, Lehigh Acres, Flordia 33936												
and and lealth m 27		_	Thomas D. Angle /	Son		20h						203, Lehig Date			
Pages 1 nent of H ant: If ite		2	0a. Method of Disposition 1   □ Burial 2 □ Cremation	3 □R	emoval from	State Zob.	Place of Disp cemetery, cre	ematory or o	ther plac	e)		Date	20c. Local	tion - City or	Town, State
Pag ment ury			`4 ☐ Donation 5 ☐ Other (S	_		Sac	ered Hea	rt Ceme	tery	ļ N	lay 1	2, 2005	Bushwo	ood, Mar	yland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If it first 71 is marked other then "natural, or items 23a or 28a-f show any wjury or other treumatic event, I'v. Medical Examinat must be notified at	SUCE	21. Signature of Funds Service License  22. Name and Address of Facility  Mattingley-Gardiner Funeral Home. P.A. P.O. Box 270, Leonardtown, Maryland 20650													
Physicia /Medic		1	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a												Approximate Interval Between Onset and Death
certificate be executed with the physician and was the burial-transit	dicai Examiner	r	Sequentially list conditions, any, leading to immediate ause. Enter Underlying Lause (Disease or injury hat initiated events esulting in death) Last		Due to	4	tensi	en.							710445
box of anth certification attending processes as	Physician/Medi		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	2	1 Live b	come of pregreath 2 Fet predicts at time of the pown	al déath 3	□Ectopic pr					230	I. Date of deli Month	ivery Day Year
wrequires that the de been signed by the should be detached	þ	Taking of the second se													
ne la la la la la la la la la la la la la	ompieted										autop perfor	24a. Was an autopsy performed?  1 \( \rangle \) Yes 2 \( \sqrt{N}\) No \( \) No \( \) Were autopsy findings available prior to completion of cause death?			
VICAL P Sicien: Th s certificate firector, pag	3e C	1 2	5. Was case referred to medica							26. Place	of Deat	h (Check only o			
d is	ToB		examiner? 1 ☐ Yes 2 ☐ No	Н	lospital: 1 □ I	Inpatient 2[	☐ ER/Outpatie	ent 3 DC	Oth	er: 4 🗆 Nu	ırşıng Ho	me 5 esid	ence 6	Other (Spec	cify)
ding After fune		TEMPARATE 2 EVOLUTION SET TO A STATE OF THE									ccurred				
DIVISION  el or Attending s after death. Il Director: After	Certification:		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)					
To the Hospitel or Attency within 24 hours after death To the Funerel Director: completely filled in by the	edical C	2	29a. Certifier 1 Certifyir (Check only one) 2 Medical	g Phys Examii	ner: On the b	best of my kr asis of examir ner stated.	nowledge, dea nation and/or i	th occurred nvestigation	at the tin	ne, date an pinion, dea	d place, th occur	and due to the dred at the time, d	ause(s) and pla	d manner as ace, and due	stated. to the cause(s)
To the within 2 To the complet	Me		9b. Signature and title of certifie	r				290	c. Licens	e number			29d. Date s	igned (Monti	h. Day, Year)
⊢ s ⊢ ŏ			· all	al				-		<b>3</b>			(	lala	5
0.1			0. Name and address of person	who oo	moleted caus	se of death (the	om 23a) /Tues		(00	210			)	10/0	5 20636
مولاي		-		***************************************	protou caus	- 2	coa, (Type	, : ::::::) .A. 3!	40	- 1	1	1000 -	00.3	417	201-21
ALC: YES	Ctot	7	Dr. AmiSh Sha Bl. Date filed (Month, Day, Year)	<u>-</u>	32 1	legis ar's Sigr	nature	NOTC	n K	oad	1-1	toky wo	ood,	MO	20000
30	State istrar			10	2005		, B	Loon	D						

State of Maryland / Department of Health and Mental Hygiene Amended 1- State item# 16b, Talbot, 05-04-05, srCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 Month April **Physician** 28 9:00 Рм Andrews Marlene /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Centreville Queen Annes 936 Dulin Clark Road If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F 68 Director 241-66-8252 Feb.9,1937 North Caroline Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28e-f show treumetic event, the Madical Exercities roust be notified at 1 ☐ Yes 2 No Director Centreville Maryland Queen Annes 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code ō death with or items 23e USA 21617 Funeral 936 Dulin Clark Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 Û No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. þ 3 Widowed 4 Divorced Black naturel Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. other then " College (1-4or 5+) Own home Elementary/Secondary (0-12) Some one else's home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental H is marked ott Be Pages 1 and 2 should be ment of Health and Menta tent: If item 27 is marked jury or other treumetic ev Blanche Brown West Joesph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) \_Andrews / Husband 936 Dulin Clark Road, Centreville, Maryland 21617 .Iohn 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. 05-03-2005 4 ☐ Donation 5 ☐ Other (Specify) Centreville, Maryland Chesterfield Cem. 22. Name and Address of Facility
Bennie Smith Funeral Home 21. Si Ture of Fundinal Gervice License /1/ W. Division Street, Dover, Delaware 19904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ovarian **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of). Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 ☐ Yes 2 ☐ No 2 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 Ž No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this nerel Director: After thi filled in by the funeral Manner of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \( \text{Homicide} \) within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier 1)47232 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 509 Idlewild Dr. Mary S. Deshields Easton, Maryland 21601 31. Date filed (Month, Day) 2005 Segistrar State Registrar

			1 - For State Registrar	State of	Marylar		artmen rtificat			and M		gien Reg. N	200	)5		109
	Physici /Medic		Decedent's Name (First, Middle	e, Last) Clyde E.	Brown	, Sr.					2. Date of De Month May	eath Da		Year 005	3. Time	of Death
	Examin		4a. Facility Name (If not institution Union Hospita	n, give street and num	ber)		Ell	kton	Location o			40	Ceci	il		
	Funeral Director		5. Social Security Number  166-16-7421  Usual Residence of Decedent	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. 86	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da OCT 27	ay, Year			olace (State ntry) SYIVa	te or Foreign ania
	ith the Maryland or 28a-1 show as notified at	Director	10a. State 10b. County  Delaware New C  10e. Street and Number			ty, Town or Lo	10f. Zip	Code				10g. C	itizen of W		1 🗆 Y	e City Limits
036	72 hours after death with the Maryland "naturel", or Items 23a or 28a-1 show idical Examiner must be notified at	by Funeral	12 Cameron La:  11. Marital Status  1 Never Married 2 Mar  3 Widowed 4 Divorced	12. Was Dece	ces? Wor 2□No War	s. 13. Id II			spanic Ori n, Mexican Specify:		cify Yes or No Rican, etc.)			- Americ , White,	can Indian	),
21215-0036	n na	Completed	(Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed)	4or 5+)	(Give	dent's Usua kind of wo DO NOT us	rk done a se retired	urina mos	t of workin	ng		Kind of Bus			
Maryland 2	be filed tal Hyg d otha evant,	To Be Co	12 17. Father's Name (First, Middle, Ephraim Brown	Last)		Ma	inten	ance			(First, Middle	, Maide			ore_	
Baltimore, Mary	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumetic. once.		Sandra Jeffer  Sandra Jeffer  20a. Method of Disposition  1 □ Burial 2 ☑ Cremation  '4 □ Donation 5 □ Other (5)  21. Signature of Funeral Service	y/Daughter 3	20b. F	12 C: Place of Disposemetery, creickessin	omerolosition (Nar matory or o n Crei	n Lai ne of other place mator	ne Numbe	er or Rura   War   May   1   2005	Route Numb	awar 20c. L	or Town, S 197 .ocation - C	713 City or To	own, State	
V	whysician and // // // // // // // // // // // // //	Examiner	23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	ich line.	th. Do not enforce of):  OSIS  Luence of):	D3 W. ter the mod	Stor le of dying	ckton	Str	eet, E	lkto	n, Ma	-	Approxim Interval I Onset ar	nate
s, P.O. Box 68760,	s that the death certificate gned by the attending phys se detached for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditi	4☐ Pregna 9☐ Unkno ons contributing to de	rth 2 □ Feta int at time of c wn ath but not res	al death 3 [ death 5 [ sulting in the u		ause give	on in Part I.				23d. Date Mont	th bute to ti	Day he cause o	
Il Records,		Completed	Muse	scleroli	, VI-E	are L	Sea	we			24a. Was auto perfo		24b. W	ere auto	posv findin	gs available of cause of
Division of Vital	utanding Physician: Th death. ctor: After this certificate y the funeral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pendii invest	Hospital: 1 In		ER/Outpatier 28b. Time o Injury		28c. Injury Work	r: 4□Nu	rsing Hom	(Check only one 5 ☐ Resi	idence			ýy)	
Divis		I Certification:	3 Suicide 6 Could determ	nined 286. Place buildin	of Injury - At h	fy) 			o dots -		8f. Location ( City or To	wn, Stat	Θ)			lumber,
	To the Hospital or a within 24 hours after To the Funaral Dire completely filled in b	Medical	(Check only 2 Medical one)	ng Physician: To the Examiner: On the ba and mann or	sis of examina er stated.	ation and/or in	vestigation	, in my op	inion, dea	th occurre	d at the time,	date an	d place, ar	nd due to	the caus	
	Sta Registr	ite	30. Name and address of person S. S. S. S. S. S. S. S. S. S. S. S. S.	who completed cause  EV M D  32. Re	of death (Iter	n 23a) (Type, <b>North</b> ature	St &	Sui!	E3	в,	Elk	tor	M	72	192	<b>/</b> .

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State

Registrar

MAY 2 0 2005

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death UJ Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Currence Lucille Virginia /Medical 4a. Facility Name (If not institution, give street and number). 4h City Town or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, Apr 23, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year 9. Birthplace (State or Foreign **Funeral** Days Min 1 ☐ M 2 🔀 F Director 1912 232-09-0739 93 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at Allegany MD LaVale 1√ Yes 2 No Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 26 North Woodlawn Avenue 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after de al Hygiene. other then "neturel", or Item 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1□Yes 2≹No Specify: Specify: white à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient Important: If item 27 is marked other the any niury or other traumatic avant. It suc. teacher elementary school 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **Dorsey Currence** Myrtle Whitehair Currence ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12418 Stoneybrook Lane LaVale MD 21502 Robert Reinhart attorney 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Maplewood Cemetery 5/18/2005 WV Elkins \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat0re of Funerat\Service Licenses 22. Name and Address of Facility
Scarpelli Funeral Home, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MASSIVE STROKE Priysician /Medical Due to (or as a consequence of): **Examiner** ITS DIRATION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit TRIAL Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physiclan/Medical the as IF FEMALE: 981 If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No. 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has autopsy 2 No 1 Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 1 ☐ Yes 2 No 2 1 inpatient 2 ER/Outpatient 3□ DOA this funeral c 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attanding Pl
 24 hours after death.
 Funaral Diractor: After ti Certification: 1 X Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 TSuicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funaral D 1 🗷 certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28622 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SABAHAT NAWAB, MD PO BOX 205 Grantsville, 32. Registrar's Sir pature State Registrar

			For State Registrar	State	of Maryla		artment of H		ınd M		giene Reg. No,		Boundary	D Miles	1 1 0
	Dhuaisi		1. Decedent's Name (First, Middle, L	ast)						2. Date of Dea	ath S	Z U U	ear	3 Time o	Death Z
	Physicia /Medic		Thomas	Freder		Ch	andler, Jr			May	6	20	05	8:55	A M
	Examin	er	4a. Facility Name (If not institution, g				4b. City, Town, o		f Death		4c.	County of			
			12807 Bowling 5. Social Security Number 6.	Street,	-	s. last birthday)		erland	24 Hrs.	8 Date of Birt	th	A1	lega	ny Iaco (Stato	or Foreign
	Funeral Director		217-10-1034	1 <b>X</b> M 2□F	86	Yrs.	Months Days	Hours	Min.	8. Date of Birt (Month, Da 08/13/1	y, Year) 918	M	Coun laryl	lace (State try) and	or roraign
	ס		Usual Residence of Decedent		1	-									
	anylan show	L	10a. State 10b. County		10c. 0	City, Town or Lo	ocation						1	Od. Inside C	City Limits 2. ☑ No
	Ba-13	Director	MD Alle	gany			Cumberland								2.(\$) (10)
	with the		10e. Street and Number 12807 Bowling	Street.	SW		10f. Zip Code	1502			-	zen of Wha JSA	at Coun	try?	
	filed within 72 hours after death with the Maryland Hygiene. Ithar than "natural", or Itams 23a or 28a-f show ant, the Medical Evantinat must be notified at	Funeral	11. Marital Status		edent Ever in	U.S. 13.			in? (Spe	cify Yes or No		14. Race -	Americ	an Indian.	
_	fter d	Fun	1 Never Married 2 Married	Armed F	orces? 2 □ No ive		Was Decedent of H If Yes, specify Cubi		, Puerto F	Rican, etc.)			White,		
200	al', o	ρ	3 ¼ Widowed 4 □ Divorced	If Yes, G Year or I		'II	1 ☐ Yes 2 💢 No	Specify:				Specity:	V	Mite	
ָ ה	72 hc	Completed	15. Decedent's (Specify only highest of	Education rade completed,	1	(Give	dent's Usual Occup	during most	of workir	ng	16b. Ki	nd of Busir	ness/Ind	lustry	
Ā	han,	ldu	Elementary/Secondary (0-12)		1-4or 5+)	life.	DO NOT use retire	d) _							
V	led v lygie har t		11 17. Father's Name (First, Middle, Lat	21)		P:	ipefitter F		r's Name	(First, Middle,		11road			
מומ	d be f antal h sad of	o Be		ederick	Ch	andler,	Sr.	Flore		(First, Middle,	Wild Golf		Valte	re	
ary	Shouls nd Me mark mati	오	19a. Informant's Name/Relationship		OI.		ng Address (Street			Route Numbe	er, City o				
Ž	nd 2 ilth ar		Thomas F. Chandler,	III / son	ı	1280	7 Bowling S	treet.	Cumbe	rland, M	1D 21	L502			
Ę.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Hasilth and Mental Hygiene. Important: if time 27 is marked other then "natural; or items 23e or 28e-1 show any injury or other traumatic event. It a Medical Eventrical mast be notified at once.		20a. Method of Disposition		20b.	Place of Dispo	osition (Name of matory or other place	ce)	D	ate	20c. Lo	cation - Cit	y or To	wn, State	
	Page nent c ant: if ury or		1 🕅 Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec				em. Gardens		05/10	/2005		LaVale	, Ma	ry1and	
Dallimor	permit. Departr Imports any inju		21. Signature of Juneral Service Lic	ensee	7 .	22	2. Name and Addre			-			,		
0	20 = 20		Lakert	C. U	dom		404 Decat					ry land	21		
ļ	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	mplications that ly one cause on	each line.		ter the mode of dyir				rrest,			Approxima Interval Be Onset and	tween
	/Medical Examiner		resulting in death)	Due to	(or as a conse					<u> </u>					
	7	- G	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin	b. — Due to	(or as a conse	equence of):									
	uted t insit	Examiner	Cause (Disease or injury		,										
5	ate be executed hysician and the burial-transit	Exa	that initiated events resulting in death) Last	c. Due to	(or as a conse	equence of):									
000	ite be iysicie ne bui	dlcal		d.											
0	ntifica ng ph a as th	Med	IF FEMALE:												
20	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Iclan/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	itcome of preg birth 2 □ Fe	tal death 3	Ectopic pregnancy	,			2	3d. Date o			Year
5	the a	slc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Preg 9□Unkr	nant at time of nown	death 5	Other (specify)							,	
Ŀ	The law requires that the te has been signed by thoage 2 should be detached.	Physi	Part II. Other significant conditions	contributing to	death but not re	esulting in the u	inderlying cause giv	ren in Part I.		23e. Did to	obacco u	se contribu	ate to th	e cause of	death?
ກົ	uires I sign Id be	d by	Alzheimer's,	Parkinson	's Diseas	se				1 🗆 Y	/es 2[	]No 3(	_ Proba	ably 4 📑	Unknown
cords	w req	lete								24a. Was	an	24b. Wei	re autor	sy findings	available
ב	The lav	Completed								autop	rmed?	prio	r to con th?	npletion of o	cause of
		ø	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes (Check only o			1 95	2□ No	
>	Physician: this certific ral diractor.	To B	examiner? 1 🎇 Yes 2 🗌 No	Hospital:	Inpatient 2	⊒ ER/Outpatier	nt 3 DOA Oth	ler: 4 □ Nur	sing Hom	ne 5 ∏ Resid	dence 6	Other (	(Specify	)	
5	ng PI fter th		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time o Injury	f 28c. Injur Wor	y at rk?	2	8d. Describe h	now injur	y occurred			
SION	tendii eath. or: A the fu	catio	2 Accident investigat				M 1 🗆	Yes 2□N	-						
<u> </u>	tal or Attending Physis:s after death. al Diractor: After this coed in by the funeral dire	Certification:	3 Suicide 6 Could not 4 Homicide determine	200. Flac	e of Injury - At ling, etc. <i>(Spe</i>	home, farm, str cify)	reet, factory, office		2	8f. Location (S City or Tow	Street and vn. State,	d Number ( )	or Rurai	Route Nun	nber,
_	spital or Atten ours after deat aral Diractor: filled in by the		29a. Certifier 1 ☐ Certifying I	Physician: To th	e hest of my k	nowledge deat	h occurred at the tir	me date and	d place a	nd due to the	causa(s)	and mann	or as st	atod	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medicel Ex	eminer: On the	asis of examination and the state of the sta	nation and/or in	vestigation, in my o	pinion, death	h occurre	d at the time,	date and	place, and	due to	the cause(	s)
	To tha Hos within 24 h To tha Fur completely	Me	29b. Signature and title of certifier	111			29c. Licens	e number			29d. Date	e signed (M	Month, L	Day, Year)	
1	B/ IUA		) (N/0 /	Ki-	~		DC	9157			May	7 6, 20	005		
)	7		30. Name and address of person wh												
	MNS		Paul Snow,				et, Cumberl	land, Ma	ary lar	nd 21502	2				
	Sta Registr		31. Date filed (Month Day, Year)	005	Registrar's Sig	nature	own								

		For State Registrar		rtificate of Death	Reg. N	2005 1711
Physic /Medi Examii	cal	Decedent's Name (First, Middle, Last)     ELIZABETH H. DECKE      4a. Facility Name (If not institution, give seems)	GR	4b. City, Town, or Location of Dea	MAY 1	year 2005 3. Time of Death 3. Time of De
Funeral Director		ANNE ARUNDEL MEDIO 5. Social Security Number 6. Sex 219-64-8142		ANNAPOLIS  If Under 1 Year If Under 24 Hr  Months Days Hours Mir	s. 8. Date of Birth	
e Maryland 3e-f show tified at	Director	Usual Residence of Decedent           10a. State         10b. County           MD         ANNE ARUN	10c. City, Town or Lo			10d. Inside City Lim 1 ☐ Yes 2 🙀
perrait. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28e-f show may njury or other treumatic event, the Modical Examinar must be notified at Once.	Funeral Dire		12. Was Decedent Ever in U.S. Armed Forces?	10f. Zip Code  21403  Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	US	A  14. Race - American Indian, Black, White, etc.
72 hours afte "naturel", or I	þ	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade	Year or Dates: cation 16a. Dece	1 ☐ Yes 2 ▼ No Specify:  dent's Usual Occupation kind of work done during most of wo	orking 16b.	Specify: WHITE  Kind of Business/Industry
be filed within tal Hygiene. d other than event, the Mc	Be Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+) HOMEN		me (First, Middle, Maide	OWN HOME
nd 2 should be filed w lith and Mental Hygier 27 Is marked other tt r treumatic event, Ibs	10.	ROBERT C. BOWEN  19a. Informant's Name/Relationship (Type  ELIZABETH SHEFFEY/		HAZEL ng Address (Street and Number or F MCKAY ROAD, STEV		
pernit. Pages 1 and 2 Dep. rtment of Health Important: If item 27 any njury or other tre		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State 20b. Place of Dispo cometery, crem HILLCRES CEMETERY	sition (Name of natory or other place)	Date 20c.	Location - City or Town, State
Department of the control of the con		21. Signati Fune at S rvice License  23a. Parti. Enter the disease, or complishock, or heart failure. List only on	cations that saused the death. Do not ent	or the mode of dying, such as cardia	CHESTER, M	FUNERAL HOME, P.A. D. 21619  Approximate Interval Between Onset and Death
Medical hysician and hysician and hysician the burial-transit	licai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	y disease		years
rifysterin. The taw requires that the death certificate that been signed by the attending phy ral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) 9 \( \text{Unknown} \)		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
w requires that in been signed by should be detact	ed by Ph	diabetes	tributing to death but not resulting in the u			use contribute to the cause of death
icten: The law ro certificate has be rector, page 2 sh	Completed	•	lascular disease		24a. Was an autopsy performed?	24b. Were autopsy findings availad prior to completion of cause death?  1 Yes 2 No
no the mospher of attending mysticient. The within 24 hours after death.  To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Certification; To Be	27. Manner of Death Natural 5 Pending investigation 3 Suicide 6 Coulon be	ospital: 1 Inpatient 2 ER/Outpatien  28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28b. Place of Injury - At home, farm, str	Other: 4 Nursing  28c. Injury at Work?  M 1 Yes 2 No		ury occurred  and Number or Rural Route Number,
4 2 8 5	ert	4 Homicide	building, etc. (Specify)	a cooured at the time, date and place	City or Town, Star	
within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	edical C	29a. Certifier (Check only one)  Certifying Physical Examination	sician: To the best of my knowledge, death ner: On the basis of examination and/or in- and manner stated.	vestigation, in my opinion, death occ	urred at the time, date ar	nd place, and due to the cause(s)

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 10:40 AM MAY 14 2005 WILLIAM FALCONE 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | APR . 7, 1929 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 1⊠M 2□F 76 WASH. D.C. 577-30-9375 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 □ No MARYLAND FREDERICK **EMMITSBURG** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 2ND AVE. 61 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2K No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ENGINEERING FIRMS DRAFTSMAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) MARY GUIESEPPI VALENTINO FALCONE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 61 2ND AVE., EMMITSBURG, MD. 21727 ISABELLE FALCONE/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State NEW ST. JOSEPH'S 5/21/2005 EMMITSBURG, MD. 21727 \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Fugeral Service Licensee/ 22. Name and Address of Facility SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Day cute myocardial Farction Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ₩Unknown ONGESTIVE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an DPTCS autopsy performed? Chronic 1 Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D5164 Shah Hiren, me 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) honson lhama

Division of Vital Records, P.O. Box 68760, a Hospital or Attanding Physician: The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

Director

Funerai

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Completed

Be

Examiner

Physician/Medical

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Completed

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Certification: To

Medical

31. Date filed (Month, Day, Year)

MAY 2 0 2005

**Funeral** 

Director

or than "naturel", or Itams 23a or 28a-f ahow the Medical Examinar must be institled at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ent If itam 27 is marked other than "naturel", or Ita

permit. Pages Department of Importent: If it any injury or o

Physician

/Medical

**Examiner** 

detached for use as the burial-transit

the attending physician and

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Fo the Funaral Director; After

filled in by the

death.

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Baltimore,

death with the Maryland

DHMH 17 Rev 1/2001

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State

Registrar

distrar's Signature

Physicia	an	1. Decedent's Name (First, Middle, Last)		l. Date of Death Month 1ay	11 2005	3. Time of Deat 11:50 A
/Medic	al -	ANDREW DAVID GIBSON  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or	Location of Death	iay .	4c. County of Death	11:30 A
Examin	C	6 Mariners Way, Unit 4 Stevens	ville		Queen Anne	
Funeral Director		5. Social Security Number  213-08-8260  Usual Residence of Decedent  6. Sex 1	Hours Min.	Date of Birth (Month, Day, You FEB 16,	ear) 9. Birthpla Countr MA.RY	LAND
ims 23a or 28a-f show		10a. State 10b. County 10c. City, Town or Location		-	100	d. Inside City Lim
28a-f	rect	MD QUEEN ANNE S STEVENSVILLE  10e. Street and Number 10f. Zip Code		10g	. Citizen of What Countr	ry?
3a or	O	6 MARINERS WAY UNIT 4 216	666		USA	
Department of Health and Mental Hygiene. Important: or itams 23a or 28a-f show Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show eny injury or other traumatic avant, the Medical Examinar must be recilled a once.	by Fur	11. Marital Status  1 X Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Specify Cubar It Yes, Give Year or Dates:  13. Was Decedent of His If Yes, specify Cubar It Yes, Give Year or Dates:	spanic Origin? (Specif n, Mexican, Puerto Ric Specify:	fy Yes or No- can, etc.)	14. Race - America Black, White, et Specify: WHIT	tc.
e. an "natur Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  16a. Decedent's Usual Occupa (Give kind of work done diffe. DO NOT use retired)	durina most of working		b. Kind of Business/Indu	
lygien her th nt, the	S	12 2 BARBER	18. Mother's Name (/		HAIR STYLIS	ST
ed of	9 Be	17. Father's Name (First, Middle, Last)  LESTER A. GIBSON, JR.	BETTY JE		- ·	
nd Me mark imatik	2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street a				Code)
alth ai 27 is er trau		BETTY VAN GILDER/MOTHER 701 FIRST ST.			-	
of Hei fitem rothe		20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place	Θ) Dat	te 20	c. Location - City or Tow	n, State
ant: I		`4 □Donation 5 □Other (Specify) OXFORD CEMETERY	5-15-2	and the same of th	OXFORD, MAR	
Depart Import eny in		21. Signature of Funeral Service Licensee  22. Name and Addres FELLOWS, HE 200 S. HARR	ss of Facility ELFENBEIN & RISON ST EA	NEWNAM	FUNERAL HO D 21601	ME PA
nysician Medical Vaminar		Immediate Cause (Final disease or condition resulting in death)  A. Methadone Intoxication Due to (or as a consequence of):				Onset and Deat
Medical xaminer prize pr	Ilcal Examiner	disease or condition resulting in death)  Methadone Intoxication				Onset and Deat
Medical xaminer prize pr	Ical	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injuly that initiated events  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):			23d. Date of deliven	Onset and Deat
Medical xaminer prize pr	by Physician/Medical	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Clause (Disease or in fighty that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	en in Part I.		23d. Date of deliven	Onset and Death  y Day Year
Medical xaminer prize pr	Completed by Physician/Medical	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in fig.) that initiated events resulting in death) Last  Due to (or as a consequence of):		1 Yes  24a. Was an autopsy performer 1 Yes 2	23d. Date of deliven Month Coco use contribute to the 2 No 3 Probal 24b. Were autops prior to com death?	Day Year cause of death
Speed in a signed by the attending physician and seen signed by the attending physician and seen signed for use as the burial-transit	by Physician/Medical	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of higher) that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or	26. Place of Death (6) er: 4 Nursing Home (7) ext (7) Yes 2 No 28) 4 ne, date and place, and pinion, death occurred	24a. Was an autopsy performer 1 Yes 2 Check only one) 5 Residence d. Describe how f. Location (Stree City or Town, S Stenven d due to the cause at the time, date	23d. Date of delivery Month  2 No 3 Probal  24b. Were autops prior to come death?  1 No 1 News 2  25e 6 Nother (Specify); injury occurred  25tate 6 Marine Sville, Marses (s) and manner as sta	onset and Death  y  Day Year  cause of death  bly 4 Cunknows  sy findings avail- pletion of cause  Poly No  at scene  Route Number,  yland  ted.  the cause(s)

		1 - For State Registrar	State of Marylar	nd / Depa	artment		Mental Hy	_	05	17117
Physic /Medi Examii	cal	1. Decedent's Name (First, Middle, Last Charles Reube 4a. Facility Name (If not institution, give	n Heath, Sr	rter	4b. City, T	own, or Location of Dea		Y 14,	Year 2005 ty of Death Balt	3. Time of Death  11:25 M
Funeral Director		Social Security Number 6. Se			If Under 1		8. Date of Birtl	1923	9. Birthpl	ace (State or Foreign fry) ginia
the Maryland 28e-f ehow	Director	10a. State 10b. County  MD Baltimo		ity, Town or Lo		Code		10g. Citizen o		Od. Inside City Limits 1 ☐ Yes 2 ☑ No try?
Baltimore, Maryland 21213-U036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other treumatic event. The Medical Examinative Inditional anong.	by Funeral Di	20222 Middletc  11. Marital Status  1 □ Never Married 2 □ Married	Wn Road  12. Was Decedent Ever in U Armed Forces?  1 ☐ Yes 2 MNo If Yes, Give			053  ent of Hispanic Origin? (: fy Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		ace - Americ ack, White, e	
Baltimore, Maryland 21215-UU36 permit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. Importent; if item 27 is marked other than "natural", or any injury or other treumatic event. The Medical Expanpure.	Completed by	3 XWidowed 4 □ Divorced  15. Decedent's Edi (Specify only highest grace Elementary/Secondary (0-12)	Year or Dates:	16a. Deced (Give life.	dent's Usual kind of work DO NOT use	Occupation done during most of wo retired)	orking	16b. Kind of		lustry
YIBNG ZI could be filed w Mental Hygie varked other ti vatic event. In	To Be Col	6 17. Father's Name (First, Middle, Last) Edward Heath			spec.	18. Mother's Na Mand	me (First, Middle, y Wyneg	Maiden Suma ar	ame)	
offe, Mar		19a. Informant's Name/Relationship (T) Charles R. Heath, 20a. Method of Disposition	Jr./Son		22 Mi	(Street and Number or ALddletown			d, MI	21053
<b>Baltimo</b> permit. Page Department of Importent: If any injury or once.		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Synature of Yunery Servic Liens	Mi	ddletov 22	vn Ceme 2. Name and	,,	)5 .J. Harte	Freelnedom.	Mortu	ary, Inc.
Pnysician /Medical		23a. Part 1. Enter the disease, or comp shack, or peart failure. List only o Immediate Cause (Final disease or condition resulting in death)	_ ACUTE MYC	th. Do not ent	er the mode	of dying, such as cardia				Approximate Interval Between Onset and Death DNE DAY
Examiner	Jer		Due to (or as a consect DILATED C	CARDIO	MYOPA	YHTF			1	MONTHS
ate be executed sysician and he burial-transit	icai Examiner	resulting in death) Last	Due to (or as a consect)		Y DIS	SEASE				YEARS
the death certification by the attending phicked for use as t	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of o	aldeath 3□	Ectopic pre			1	ate of delive	ry Day Year
wrequires that ween signed b should be deta	ed by Pi	Part II. Other significant conditions co	•	sulting in the u	nderlying ca	use given in Part I.				e cause of death? ably 4 Unknown
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ding Phy	tion: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury		Other	eath (Check only on Home 5 Resid	lence 6 🗆 O		.*
To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	i Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h	ify)			28f. Location (S City or Tow	m, State)		
To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Medical	(Check only one)  2 Medicel Example one)	sicien: To the best of my kniner: On the basis of examina and manner stated.	ation and/or in	vestigation,	t the time, date and place in my opinion, death occ License number	urred at the time, o	cause(s) and ridate and place	e, and due to	the cause(s)
6		30. Name and address of person who c	ompleted cause of death (Item	m 23a) (Type,	Delen)	017695	/	viug	14	2003
Sta Regist		ABDALLAH J. HE 31. Date filed (Month, Day Year) 20	105 32/2 pgistrar's Sign.	601		DRIVE, TO	WSON, N	19RYLE	ND 2:	2014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Charles Humbertson 4:20p May 12, 2005 Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 507 Prince George Street Cumberland Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, NOV 15, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1₩ M 2□F MD ( 220-10-8963 86 Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show item 27 is marked other than "neturel", or items 23a or 28a-f show other treumetic event, the Madical Experient must be mailfied at MD Allegany Cumberland 1 ☐ Yes 2 ☐ No To Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 507 Prince George Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Ø Yes 2 □ No If Yes, Give Year or Dates: WWW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours atter onent of Health and Mental Hygiene. ant: If item 27 is marked other than "neturel", or itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2ĂNo Specify: white 3 Widowed 4 Divorced WW II 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerk U.S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Azariah Humbertson Mary Elizabeth Anderson Humbertson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn Miller daughter 12712 Lewis Heights Dr, Cumberland MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, State Department of H
Important: If ite
eny injury or ot
once. 1 

Burial 2 □ Cremation 3 □ Removal from State St. Mary's Cemetery 5/16/2005 Cumberland MD <sup>4</sup> □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, P.A. 21. Signature of Funeral Service Licenses 108 Virginia Avenue; Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hypertensive Cardiovascular Heart Disease years disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav 4 Pregnant at time of death 5 Other (specify) P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Aortic Valve Disease Previously Resected 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown tuneral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2∏ No 1 🗌 Yes 20 No 1 TYas 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 XYes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funerel C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) THOW M. D D09157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Snow M.D 31. Date filed (Month, Day, Year) 124 W. 3rd Street Cumberland MD 21502

DHMH 17 Rev 1/2001

State Registrar

MAY 2 0 2005

ORIGINAL

32. Registrar's Signature

			1- State of Maryland / Den State of Maryland / Den Pegistrar	partment of Health and I or me 6845 7-1-05 t ertificate of Death	Mental Hyg	giene
	Physic	ian	Decedent's Name (First, Middle, Last)		2. Date of Dea Month	
	/Medi Examir		Janice Carolyn Hall  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	April	30 2005 0700 A M
	<u> </u>		Union Hospital	Elkton		Cecil
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthda Yrs. 414-66-8220	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day	(Year) Country)
	yland		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	death with the Maryland rms 23a or 28a-f show r must be notified ≡t	Director	Maryland Cecil Elkton			1 ☐ Yes 2 💆 No
	with th		10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Country?
	death	Funeral	21 Sadler Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	United States 14 Race - American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other traumatic event, Ite Medical Examiner must be notified at once.	by Fu	Armed Forces?  1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No  If Yes, Give  Year or Dates:	If Yes, specify Cuban, Mexican, Puèrti 1 ☐ Yes 2X No Specify:	o Rican, etc.)	Black, White, etc.  Specify:
2-00	72 hou natura lical E	ted	15. Decedent's Education 16a. Dec	edent's Usual Occupation		White  16b. Kind of Business/Industry
121	within 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of wor. DO NOT use retired)		4 3: 1 4 6
d 2	filed v I Hygie other i	Be Co	11 Pa	icker 18. Mother's Nam	ne (First, Middle, I	Medical Manufacturing Maiden Sumame)
Maryland 21215-0036	should be nd Mental marked o	To B	Pate Jones	Ray Va	anDyke	
Mar	d 2 sho th and 7 is m traum			ling Address (Street and Number or Ru		
	item 2		20a. Method of Disposition 20b. Place of Disposition	Little Egypt Road,	Date	Maryland 21921 20c. Location - City or Town, State
altimore,	Page Iment tant: H jury or		1 XBurial 2 □ Cremation 3 □ Removal from State G11D11 of the Company of the Comp	ematory or other place) May Manor 2005		Elkton, Maryland
Bali	permit. Departimporta		March & Hills ) H	22. Name and Address of Facility icks Home for Fune	erals, P.	Α.
	ysician		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	03 W. Stockton Str nter the mode of dying, such as cardiac an Fai ( we	cet, Elk or respiratory arre	est, Maryland 21921 Approximate Interval Between Onset and Death
1	#Medical Examiner		Due to (or as a consequence of):	slack		
10	p iii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Peritonitis	0	1 1
Y	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):	pMI, ca	diac	Ptent
68760,	cate ohys the	dicai	d. Small bowel perf	oration CERTIFICATION	N APPROVED BOM	OCAL EXAMINER
P.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Completed by Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
S,	ires that signed t d be det	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		pacco use contribute to the cause of death?
corc	w requir been si should	leted	1966 100 100 100 100 100 100 100 100 100 1	1 2. /		s 2.7No 3 Probably 4 Unknown
Vital Records,	The law ate has page 2 a	Сотр	Hypercholesterolemia	1000	24a. Was ar autops officin	24b. Were autopsy findings available prior to completion at cause of death?  1 No 1 Yes 2 No
Vita	certific rector.	Be	25. Was case referred to medical examiner?  1 Ayes 2 No Hospital: 1 Impatient 2 ER/Outpatient	Other	th (Check only one	9)
of	g Phye er this eral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	ont 3 DOA Other: 4 Nursing Ho of <b>unk</b> 28c. Injury at Work?	28d Describe ho	nce 6 Other (Specify) winjury occurred
Division of	ttending f death. ctor: After y the funer	catio	2 Accident investigation 4-28-05	M 1 Yes 2 No	cholecys	ijury during tectomy
Divi	5 4 4 5 C	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)  Hospital	treet, factory, office	28f. Location (Str City or Town Cecil Co	reet and Number or Rural Route Number, State) Union Hospital of bunty, Elkton, MD
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, deal control on the basis of examination and/or is and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the ca red at the time, da	use(s) and manner as stated. Ite and place, and due to the cause(s)
0	To the Youth of To the Comp	M	29b. Signature and title of certifier	29c. License number		od. Date signed (Month, Day, Year)
			30 Name and address of parent who some lated a way of the billion	D0057210		April 30, 2005
			30. Name and address of person who completed cause of death (Item 23a) (Type	D0057210 Print) 203 EIKH	fon. M	D 2(921
	Sta Registr		31. Date filed (Month, Day, Year) 32@Registrar's Signature 32@Registrar's Signature	28492		

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar	State of Maryla	-	artment of H tificate of L		-	giene 05	17120
E		1. Decedent's Name (First, Middle, Lasi	)		14		2. Date of Dea		3. Time of Death
Physicia /Medic		Franklin Milton	Hart, Sr.				May	7 200	6 18:31 M
Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of I	Deeth
		Washington County	Hospital		Hagerst	own		Washing	ton
Funeral		Social Security Number     6. Se	x 7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da)	h 3	Birthplace (State or Foreign Country)
Director		103 10 1211	XM 2□F	92 Yrs.			October	18, 1912	MD
pu &		Usual Residence of Decedent  10a. State 10b. County	10c C	ity, Town or Lo	cation				10d. Inside City Limits
aryla shor	5			,	Cation				1 ☐ Yes 2 ☑ No
he N	ect	MD Washingt	on Big	Pool	101 71 0 1		· · · · · · · · · · · · · · · · · · ·	10- 69	71
with 1	늅				10f. Zip Code			10g. Citizen of Wha	it Country?
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iter d	Ë	11. Marital Status  1 Never Married 2 Married	Amed Forces?		f Yes, specify Cubai	n, Mexican, Puerto	Rican, etc.)		White, etc.
or af	by Funeral Director	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	I□Yes 2∑No	Specify:		Specify:	I.Thai to
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othe	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,	Maiden Sumame)	- Libertino Ly
uld be Mental rked o	To E	Harry Hart				Clara N	1ills		
an yid should and Mer a marke umatic		19a. Informant's Name/Relationship (T	/pe, Print)	19b. Mailin	g Address (Street a			er, City or Town, Sta	te, Zip Code)
and 2 and 2 auth in 27 I		Deana M.Weller/Dau	ghter	12826	6 Peckton	ville RD	Big Poo	ol, MD 217	711
ひ ー ヹ る セ		20a. Method of Disposition		Place of Dispos	sition (Name of natory or other place	e) (	Date	20c. Location - City	y or Town, State
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Dalti permit. Departin Importe any inju		21. Signature of Funeral Service Licent			. Name and Addres			st Main S	
Dermi Depa Impo any id		4 King Ch.	5 10	(71	ove Fine	ral Home.			21750-0368
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lication that caused the dea	th. Do not ente	er the mode of dying	g, such as cardiac of	or respiratory an	rest,	Approximate Interval Between
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he death certifica	Physician/M	23b. was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy			1/	delivery
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ding Physicien: The h. After this certificate h. funeral director, page	Be C	25. Was case referred to medical				26. Place of Death			
Physic Physic this ce	2	examiner? 1 □ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3□ DOA Othe	er: 4 🗆 Nursing Ho	me 5 🗆 Resid	lence 6 Other (	Specify)
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or: Al	Certification;	2 Accident investigation				res 2□No			
r Attencer death	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre	eet, factory, office		28f. Location (S City or Tow	Street and Number o	r Rural Route Number,
itelo el Di	Cer								
To the Hospitel or Attending Physicien: The law requires that the death certif within 24 hours attendeath.  To the Funeral Effector: After this centificate has been signed by the attending completely filled in by the funeral director. page 2 should be detached for use a	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	sician: To the best of my kn ner: On the basis of examin	owledge, death	occurred at the tim	e, date and place,	and due to the o	cause(s) and manne	r as stated.
the I	led	one)	and manner stated.						``
To To	Σ	29b. Signature and title of certifier	· >	1 MI	29c. License	riumper	2	29d. Date signed (M	ionin, Day, Year)
		1 die	1	1 -	2745	1600	. /	MAX 10	2003
10		30. Name, and address of person who c	ompleted cause of death (Ite	m 23a) (Type	Print)	00 -4	TIM	MD.	217117
10		7414-6 (el	1027 10515	1	E NOY	18816	VUVV	11100	1142
Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Sign	ajure dos	weed (				

2)(			For State Registrar	State of M	•	partment of ertificate of		d Mental Hyg	jiene eg. No2 0 0 5	17101
			Decedent's Name (First, Middle, Las	t)				2. Date of Dea	th	3. Time of Death
	Physicia /Medic		MARY WRIGHT HEMM	ING				April	29, 2005	2:31 P M
	Examin		4a. Facility Name (If not institution, give 10 68th Street, Ui	street and number)		4b. City, Town, Ocean (	or Location of D		4c. County of Dea Worcester	th
Ī	Funeral Director		5. Social Security Number 6. Social Security Number 1	7. Ag ☐ M 2 <b>X</b> F	ne (In yrs. last birthd 78 Yrs	Months Day		Hrs. 8. Date of Birth Min. (Month, Day AUG 31	9. Bir 1926 MA	thplace (State or Foreign cuntry) RYLAND
	pun 3		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	show	ō								X□Yes 2□No
	28e-f	Director	MD WORCES  10e. Street and Number	STER	OCEAN	1 CITY		1	log. Citizen of What Co	nuntry?
	with Ba or	<u>ā</u>	10 68TH STREET,	IINIT #1			842		USA	,
	death ms 2:	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.			? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28e-f show other treumetic event, the Madical Examinating the malified at	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces: 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No	If Yes, specify Cu		uerto Rican, etc.)	Black, White	ITE
9-10	2 hou	ted	15. Decedent's Ed	ucation		ecedent's Usual Occ		working	16b. Kind of Business	/Industry
218	thin 7 e. an "n	Completed	Elementary/Secondary (0-12)	College (1-4or	- lif	ive kind of work don e. DO NOT use retii	e duning most of ed)	Working		
	ed wi	Son	11	4	F	IOMEMAKER			OWN HOME	
Maryland	be fill	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle, I		
3	d Mer narke	P L	DAVID SILVEY	Type (Briet)	106 14	ailina Addraga /Ctros			r, City or Town, State,	Zin Codel
Ma	d 2 sh th and 7 ls r treur		19a. Informant's Name/Relationship (7) S. CHARLES HEMMIN						OHIO 4414	
	1 an Heal Iem 2		20a. Method of Disposition	10, 111/50	20b. Place of Di	sposition (Name of	= 1	Date	20c. Location - City or	
no	ages ant of it: If ii y or c		1 ☐ Burial 2 ②Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		1	crematory or other p		R 5-3-2005	STEVENSVI	LLE. MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tre once.		21. Signature of Funeral Service Licen		CFSP	22. Name and Add FELLOWS,	ress of Facility HELFENB	EIN & NEWN	AM FUNERAL	
			23a. Part1. Enter the disease, or comp					ST EASTON,		Approximate
	Dharatatan		shock, or heart failure. List only	one cause on each I	ine.				•	Interval Between Onset and Death
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9	The law requires that the death certificate be executed the has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	0	IF FEMALE:	23c. If yes, outcome	of pregnancy				204 Bata of da	P
Вох	attend for us	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal death	3 □Ectopic pregnan 5 □ Other (specify)	су		23d. Date of de Month	Day Year
P.O.	the de y the ched	ıysk	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknown	time or dodn	o E Carlot (Specify)				
	res that signed by	by Physician/M	Part II. Other significant conditions of	ontributing to death	out not resulting in th	e underlying cause o	given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
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R	The law	mo				-		autops perform	med? death? 2 □ No 1 □ death?	·
Vital	ysician: The is certificate hadirector, page	BeC	25. Was case referred to medical examiner?				26. Place of	Death (Check only or		
Š	Physician: this certific ral director,	101	1X Yes 2 No	Hospital: 1 ☐ Inpati		Ment 3 DOA				cify) at scene
n c	Jing P. After t funera	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury 28b. Tim uy Yea <i>r)</i> Inju	ry W	ork?	28d. Describe he	ow injury occurred	
Sio	oteath. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be		iune. At homo, form		Tes 2 No	28f Location /S	treet and Number or R	ural Route Number
Division of	after of A	Certification;	4 Homicide determined		jury · At home, farm tc. <i>(Specify)</i>	, street, ractory, onc	Ð	City or Town	n, State)	arai riodia romber,
_	To the Hospitel or Attending Phwithin 24 hours after death.  To the Funerel Director: After the completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis and manner s	of examination and/o	eath occurred at the r investigation, in my	time, date and p	lace, and due to the coccurred at the time, d	ause(s) and manner as ate and place, and due	s stated. a to the cause(s)
	o the ithin ( o the omple	Mec	29b. Signature and title of certifier	and mainlef S	ucou.	29c. Lice	nse number	2	9d. Date signed (Mont	th, Day, Year)
	8 ± € ±		· Mayre (	helhu	elpw	0	.C.M.E.		May 1, 200	)5
(	(IL		30. Name and address of person who	completed cause of			Street,	, Baltimore	e, Maryland	d 21201
	Sta Registi		31. Date filed (Month, Day, Year) MAY 0	4 2005 Regist	ra Signature	1 Special				

		State of Maryland / Department State of Maryland / Department State of Maryland / Department Certificat	nt of Health and Me Te of Death		ene 2 0 0 5	17122
		Decedent's Neme (First, Middle, Last)		2. Date of Death Month		3. Time of Death
Physicia /Medic		Lillian Hawkins		April 29	•	12:35 P M
Examin			Town, or Location of Death		4c. County of Dee	
			treville		Queen a	
Funeral		Months	r 1 Year   If Under 24 Hrs.   Days   Hours   Min.	8. Date of Birth (Month, Day, Y		thplece (State or Foreign buntry)
Director		220-12-2103 82 Yrs.		Feb 11,1	923 Mar	yland
land ow		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Many i-f•h	tor	Maryland Queen Annes Centreville				1 ☐ Yes 2 ☐ No
If a rail of the Maryland filed within the Maryland Hygiene. Hygiene. The marker of tems 23e or 28e-1 ehow ont, the Maryland Examiner count be multified a	Director	10e. Street and Number 10f. Zig		100	. Citizen of What Co	ountry?
th with		844 Brownsville Road 2	1617		USA	
after death w	Funerai	Armed Forces? If Yes, spe	dent of Hispanic Origin? (Sp cify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
s afte	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes	2 No Specify:		Specify:	D11
72 hours	q p	3 (☐ Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usu	al Occupation	16	b. Kind of Business	Black
n 72	Completed	(Specify only highest grade completed) (Give kind of wo	ork done during most of work		D. KING OF BUSINESS	moustry
within them	фшс	Elementary/Secondary (0-12) College (1-4or 5+)  10 House Ke			Private Fa	amilies
Hygi ather	a	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		IMITICS
id be lental ked o	To B	John Gross	Gertru	ıde	Roberts	
all y allo K 1 K 1 K 1 K 1 K 1 K 1 K 1 K 1 K 1 K	_	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	s (Street and Number or Rur	al Route Number, (	City or Town, State,	Zip Code)
		Linda Coleman / Grand-daug. 844 B	rownsville Ro	ad, Cent	ceville.Ma	aryland 21617
es 1 and of Health of Health if item 27 or other tr		20a. Method of Disposition (Na.	me of		c. Location - City or	
L. Peges tment of I tent: If its		1	Cem. 05-0	7-2005	Centrevil	Le,Maryland
permit. Peg Department Importent: I eny injury o	п		nd Address of Facility e Smith Funer	al Home		
0 88558			over Street,		Aryland 2	1601
		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mod shock, or heart failure. List only one cause on each line.	de of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between
Physician	1	Immediate Cause (Final disease or condition and an arrival and arrival and arrival arr				Onset and Death
/Medical		resulting in death)  Due to (or as a consequence of):	4			( /
Examiner		Sequentially list conditions b. Den Ohera / VINCUlar	disease			morths
P #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	-/-			
ecute and -trans	cam	Cause (Disease or injury that initiated events resulting in death) Last C. LNOSTUGE CALL Due to (or as a consequence of):	aisease			years
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cate physi	dical	d. Calabres na 11/143				1100111113
ox o h certifi ending	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of de	liven
DO Path c atten for u	ian	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetel death 5 Other (see			Month	Day Year
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that hed b		Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.	23e. Did toba	cco use contribute t	the cause of death?
law requires that seem signers to should be	d by	confestive heart failure		1 🗌 Yes	2□No 3□P	robably 4 Unknown
w rec	lete	<i>d</i>		24a. Was an	24b. Were a	utopsy findings available
necolds, P.O. Box 604 The law requires that the death certificate the has been signed by the attending phys agge 2 should be detached for use as the	Completed			autopsy performe	prior to death? ZNo 1 ☐ Yes	completion of cause of
VICAL Ician: T certificat ector, pa	4	25. Was case referred to medical	26. Place of Deat	th (Check only one)		<i>y</i> = 110
ysici is cer direc	OB	examiner? 1   Yes 2   No	OA Other: 4 Nursing Ho	ome 5 Residen	ce 6 □Other (Spe	city)
ig Phy ig Phy ier this	T:U	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how	injury occurred	
VISION r Attending er death, rector: Afte	atic	2 Accident investigation	1 ☐ Yes 2 ☐ No			
r Atte	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	y, office	28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
Itel o						
To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifying Physician: To the best of my knowledge, death occurred (Check only 2 Madical Examinar: On the basis of examination and/or investigation				
hin 2 the I	Med	one) and manner stated.  29b. Signature,and title of certifier / 29	c. License number	296	1. Date signed (Mon	h, Day, Year)
To	_	N 1 1 2 1/2				
		1. 00-0 - 1.	47421		2.05	
		30. Name and address of person who completed/cause of death (Item 23a) (Type, Print)	01 0	.11 V	1. 1.0144	7
Sta	ito	Kathleen Hoey, M.D., 2540 Centreville I		ıııe,Mary	Tand 2161	1
Regist		MAY 0 4 2005	-			

ORIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Joseph L. Hoyer, Jr. 4. 2005 May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Memorial Hospital Cumberland Allegany If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 15€M 2□F Months Mary land 86 Yrs 218-01-4784 Director May 11, 1918 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State item 27 is marked other then "neturel", or items 23a or 28a-f show other treumatic event, "to Medical Examinat must be neallied at 1 ¥Yes 2 No Allegany Cumberland Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1424 Laurel Ct. 21502 USA death by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Tyes 2 No If Yes, Give 1046 4 14. Race - American Indian, Black, White, etc. 2 should ba filed within 72 hours after a and Mental Hygiene. Is marked othar then "neturel", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. Year or Dates: 1946-47 White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Draftsman Railroad 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph L. Hoyer, Sr. Elma G. (Deaver) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pagas 1 and 2 sh Department of Health and Importent: If item 27 is rr any injury or other treum once. Mary Alice Richardson/daughter 1424 Laurel Ct., Cumberland, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Smithsburg Crematorium 5/5/05 Smithsburg, MD of Fune a Service Lice 22. Name and Address of Facility Kight Funeral Home 309-311 Decatur St., Cumberland, MD 21502 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause Immediate Cause (Final Pulmonas **Physician** unknou disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Unknows End stag Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of) Examine The law requires that the death certificate be exacuted burial-transit Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes this 27. Manner of Teath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tille of certifier 29c. License number , 2005 May 05 D23371 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) カん Dr. Q. Zaman, Johnson Heights Medical Bldg., Cumberland, MD 21502 Registrar's Signature 0 5 State 2005 16181 Registrar

		1.	For State Registrar		State	of Maryl		artment of H rtificate of		Mental Hyg	giene	105	1710
D.	a i a i a		Decedent's Name	e (First, Middle,	Last)					2. Date of Dea	ıth	<u> </u>	3. Time of Death
	sician edical		Wilam:	ina		Blanche	2	Hink1	e	Month May 11.	2005	Year	12:30 P M
	miner		. Fecility Name (I	f not institution,	give street and n			4b. City, Town, o				y of Death	
			405 We	empe Drive	9			Cur	mberland			Allega	nv
Fune			Social Security N		. Sex		rs. last birthday)	If Under 1 Year Months Days	If Under 24 H				place (State or Foreign
Direct	tor	_	15-26-9349		1□M 2∏F	75	Yrs.	morning Days	110013	06/22/19	929		 Virginia
and *		_	sual Residence of a. State	Decedent 10b. County		100	City, Town or Lo	nation					1011111111111
anylan	ا	1		•		100.		_					10d. Inside City Limits 1   Yes 2   No
the A	l ct	10	MD e. Street and Nur		legany		(	Cumberland					
with	ä							10f. Zip Code		1	log. Citizen of		ntry?
5-UUSO 72 hours efter death with the Maryland natural', or Items 23a or 28a-1 show	Funeral Director			empe Drive		cedent Ever in	11.0	215				JSA	
ter d Item	j.	''	. Marital Status  1  Never Marri	ed 201 Marrier	Armed F	orces?	10.5.	If Yes, specify Cuba	an, Mexican, Pue	Specify Yes or No- erto Rican, etc.)	14. Hai	ce - Amen ck, White,	can Indian, etc.
irs of	À		3 Widowed		If Yes, G Year or	ive		1 ☐ Yes 2 ☒ No	Specify:		Specif	fy:	<b>тп •</b> .
ad within 72 hours eff giene. Per than "natural", or	ed d			15. Decedent's	Education		16a. Dece	dent's Usual Occup	ation		16b. Kind of B	lusiness/In	White
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be filed within 72 hours etter death with the Maryla lat Hygiene. dother than 'natural', or ferms 23a or 28a-f showent in Mulic Everil et must be rolling	e	,   17	. Father's Name (	First, Middle, La	st)				18. Mother's Na	ame (First, Middle,			
nd 2 should be file lih and Mental Hy 27 ie marked oth	7 B		Arthur	В	oettcher		McKay		Annie	Ame	lia	Hend	lershot
s 1 and 2 should Health and Men Item 27 ie marke			a. Informant's Na	me/Relationship	(Type, Print)		19b. Mailir	ng Address (Street	and Number or F	Rural Route Number	, City or Town,	State, Zip	Code)
			James V.	Hinkle, S	r. / husba	and	405 W	empe Drive,	Cumberla	nd, Marylan	d 21502		
		20	a. Method of Disp				o. Place of Dispo	sition (Name of natory or other place	(a)	Date	20c. Location	- City or To	own, State
permit. Pages Department of I Importent: If its			1 □ Burial 2 £ 1 4 □ Donation		☐Removal from			Crematory	· 1	2/2005	Cumber	land.	Maryland
permit. Departm	9	21	. Signatur of Fu	eral Service Lic	ensee					dams Family			
De De	once		Kil	*0	Del.	1	1			Cumberland			
		23	Ba. Part1. Enter th	e disease, or co	mplications that	caused the de	eath. Do not ent			ac or respiratory arre			Approximate
Physicia	an.	Im	mediate Cause (	t failure. List on Final	ty one cause on	each line.	1. /	•	0	1			Onset and Death
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icate be executed physician and sthe burial-transit	dicai				d								
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the death certifi y the attending I	Physiclan/M	23	FEMALE: b. Was decedent	pregnant	23c. If yes, ou	itcome of preg		Cataa:a			23d. Da	te of delive	ery
deat le att	100		in the past 12 i		4□Preg	nant at time o		Ectopic pregnancy Other (specify)			Mo	nth	Day Year
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w require been sign	eq	_								1 ☐ Ye	s 2 No	3 DProb	ably 4 Unknown
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g Physe er this neral di	n: T	27.	Manner of Death		28a. Date	of Injury	28b. Time of	28c. Injury	at	28d. Describe ho			7
tending Flaath. tor: After the funer	atlo		1 Natural 2 Accident	5 Pending investigati		ith, Day Year)	Injury	Work M 1□	r res 2 □ No				
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tel or Attending rs after death. el Director: Afte ed in by the fune	Certification:				Build	ing, etc. (Spe	O., y )			City or Town	, Siate/		
To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the		29	a. Certifier	1 Certifying F	hysician: To the	e best of my k	nowledge, death	occurred at the tim	e, date and plac	e, and due to the ca	use(s) and ma	nner as st	ated.
he H in 24 he Fu	Medical		(Check only one)		arryriage: On the p	pasis of exami Iner stated.	nation and/or inv	estigation, in my op	pinion, death occ	urred at the time, da	ite and place, a	and due to	the cause(s)
To the within 2 To the complet	×	29	o. Signature and t	itle of certifier				29c. License	number	29	d. Date signed	(Month, I	Day, Year)
4				- V	post	no		D332	.80		May 1	2, 200	5
1		30.	Name and addre	ss of person who	completed cau	se of death (It	em 23a) (Type. I	Print)					
nds			Suni	1 K. Gupt				Cumberland	l. Marvlar	d 21502			
	State	31.	Date filed (Mont)	Day Year)	32.1	Registrar's Sig	nature	Januar Land	-y -MALYICIL	21302			
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Division of Vital Records, P.O. Box 68760,

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		1 - State Registrar		Ctato of Mic	ii y tarr		rtificate of				eg. No.?	205	1.710	EL"
Physic		Decedent's Name (F  Irvin	First, Middle, Last)		la	cobs		Jr.	2.	Date of Dea Month	Day	Year	3. Time of Dea	th O
/Medi Exami		4a. Facility Name (If no		reet and number)	Je	CODS	4b. City, Town,		Death	5-	4c. Cour	nty of Death	0, 10	
		Franklin Sq. 5. Social Security Num	uare Hos	spital Cen	ofer us	ast birthday)	MOSeda If Under 1 Year		Hrs. R	Date of Birth	Ba		cs (State or Fo	raian
Funeral Director		216-22-72	213 <sup>1</sup> ×1	4 005	77	Yrs.	Months Days		Min.	Date of Birth (Month, Day Jun 10	, 1927	Countr	V)	aigii
Maryland f show	tor	Usual Residence of De 10a. State 10 MD	Db. County Allegany	,	10c. City	, Town or Lo	berland					100	d. Inside City Lin	
or 28e	Funeral Director	10e. Street and Numbe		1			10f. Zip Code	0.4.5.00		1	-	of What Country	y?	
death w	erai	17 Long D		2. Was Decedent E	ver in U.	S. 13.	Was Decedent of if Yes, specify Cub	21502 Hispanic Origin	n? (Specify	Yes or No-	14. R	JSA lace - Americar		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other then "natural", or itams 23s or 28e-f show pinjury or other traumatic event. The Medical Evantrian must be notified at once.	by	1 Never Married 3 Widowed 4	_	Armed Forces?  1 ☑ Yes 2 ☐ N  If Yes, Give  Year or Dates:	1945		ff Yes, specify Cub		Puerto Ric	an, etc.)	Spec	Black, White, et c <i>ify:</i> white		
in 72 h	Completed	(Specify	. Decedent's Educa only highest grade	completed)		16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	ipation during most of ed)	f working		16b. Kind of	Business/Indu	stry	
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nd 2 shou lith and M 27 is mar	-	19a. Informant's Name Bruce Jac		e, Print) SON		19b. Maifir 4109	ng Address (Stree 9 E. Bake	er Avenu	or Rural R	oute Number Abing			21009	
ages 1 au nt of Hea nt of Hea ror othe			remation 3 Re	moval from State	20b. P	lace of Dispo emetery, crer crest Me	esition (Name of matory or other pla morial Parl	ace)	Date	17/2005		n - City or Tow perland	n, State	
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1 20E 9		23a. Part1. Enter the	disease, or complica	anons that caused	the death	2	108 Vir	ginia Ave	oue: C	Lumbert			Approximate	
Frysician	,	shock, or heart fa fmmediate Cause (Fin disease or condition	ailure. List only one	gause on each lin	e. PSIS		,			,		le	nterval Betweer Onset and Deatl	
/Medical Examiner		resulting in death)	("	Due to (or as	consequ	ience of):	noun	00:0					•	
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be executed sician and burial-transit	Examiner	Cause (Disease or inju that initiated events resulting in death) Last	C.	Due to (or a	i Ca	ence :	Failur	e						
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leath certificate is attending physical attending physical attending physical attentions.	/Mec	IF FEMALE: 23b. Was decedent pro	eggant 230	c. ff yes, outcome							23d. [	Date of delivery		
the death by the attel ached for	Physician/Medic	in the past 12 mo 1 Yes 2 N 9 Unknown	nths?	1 □ Live birth 4 □ Pregnant at 9 □ Unknown			Ectopic pregnand Other (specify)	cy		_			ay Year	
w requires that the death cer been signed by the attendin should be detached for use	by	Part II. Other significant Chronic	Δ.	Failure		ulting in the u	nderlying cause g	ven in Part I.	_				cause of death	
for the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funaral Diractor: After this certificate has been signed by the attending physician plate that the defending physician by the funeral director, page 2 should be detached for use as the	Completed	MT Severe	Perealt	ral D	Seas	e T	Diabet	es Mell	- lties	24a. Was a autops perform	y	prior to comp death?	y findings avail pletion of cause	able of
sician: certific rector,	o Be (	25. Was case referred examiner?	to medical	snital:			0.	26. Place of	f Death (C	heck only on				
ig Phys ter this neral di	-	1 ☐ Yes 2 ☑ No 27. Manner of Death	5 Pending	28a. Date of Injur (Month, Day	v	ER/Outpatier 28b. Time of fnjury	IL 3 DOA	4 🔲 Nursi	7	5 🔲 Reside		other (Specify)		_
ttendin death. ttor: Af	icatic	2 Accident	investigation Could not be	28e. Place of Inju			M 1	]Yes 2 □No		Location (S)	troot and Nur	mber or Rural F	Zoute Number	
tal or A s after al Dirac	Certification:	4  Homicide	determined	building, etc			eet, factory, office		201.	City or Town		nbor or riarar	Todie Number,	
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	29a. Certifier 1 (Check only 2 one)	Certifying Physic Medicel Examine	cien: To the best of er: On the basis of and manner sta	examinat	wledge, deatl ion and/or in	h occurred at the t vestigation, in my	me, date and popinion, death	place, and occurred a	due to the cat the time, d	ause(s) and i ate and place	manner as stat e, and due to th	ed. ne cause(s)	
To the within To the comple	Me	29b. Signature and title	of certifie	0 /-			29c. Licen	se number	1	2		ned (Month, Da	y, Year)	
12		30. Name and address	of person who com		MA ath (Item		Print)	5000			5-13	)-05	*	
_		Dr. Maw C	00 9000	Frankli	n Sq	auare	Drive	Ba 1 to	more	, 14	11 21	237		
St Regist	ate rar	31. Date filed (Month, I	2 0 2005	32. Registra	K Signal	Span	W							
	_			1000		1								

DHMH 17 Rev 1/2001

			1 - For State Registrar		f Marylar		artmen rtificate			and M		leg. No.	05	17126
	Physici	an	Decedent's Name (First, Middle, La.	st)							<ol><li>Date of Dea Month</li></ol>	th Day	Year	3. Time of Death
	/Media	al	Mary	Ar		Kr	night				May 10,			9:45 A M
	Examir	er	4a. Facility Name (If not institution, giv						Location of	of Death			ty of Death	
			Allegany County No. Social Security Number 6. S		Rehab Cet 7. Age (In yrs.		If Under	mberl	and If Under	24 Hrs.	8 Date of Birth		llegan	
п	Funeral Director			_M 2∏F	85	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day 06/24/19	, Year) 119	Cou	place (State or Foreign intry) 11and
			Usual Residence of Decedent				l				00/24/17	17	1 1111	/ Land
	nylan how		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	e Ma	턍	MD All	egany		Cum	berlan	d						1 X Yes 2 □ No
	है क 8 2 8	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of	What Cou	intry?
	ath w	ā	318 Fayette Str						21502				JSA	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other then "neturel", or items 23a or 28a-f ehow or other treumatic event, the Medical Examinar must be mailited.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Dece Armed Fo 1 ☐ Yes If Yes, Giv Year or D	2 [X] No '9		Was Deced f Yes, spec 1 ☐ Yes 2		spanic Origon, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		ack, White,	icen Indian, , etc. White
Ŏ	2 ho	ted	15. Decedent's Ed			16a. Dece						16b. Kind of I	Business/Ir	ndustry
21	within 7 ene. then "n	pie	(Specify only highest gra	College (1	-4or 5+)	life.	kind of wor DO NOT us	e retired)	uring mosi	or worki	ng			
7	e filed within al Hygiene. I other then ' vent, the Me	Completed	12			]	Homen	aker					Homema	ker
Ind	be fill tal Hy d oth	Be	17. Father's Name (First, Middle, Last)								(First, Middle, i	Maiden Suma	me)	
Уa	2 should be and Mental Is marked or reumatic ev	2	George	L.		Carney			Loret			Knierie		
Nai	12 st h and 7 Is n treun	1	19a. Informant's Name/Relationship (								l Route Number	•		p Code)
e,	1 and 2 Health Iem 27		Mary Louise Leasure 20a. Method of Disposition	/ daugnte		Place of Dispo			et, G	make in the	land, Mary	y Land Z 20c. Location		own State
Baltimore, Maryland	Pages nent of int: If it		1 Burial 2 ☐ Cremation 3 ☐		State	emetery, cren	natory or of	ther place						
턆	nit. P. artme orteni injury		<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of F neral Service Licer</li> </ul>		1 5.3	S. Peter				)5/13/	ms Family	Cumber.	Land, I	Mary land
Ba	permit. Page Department Importent: If any injury or once.		Xebert C.	Man.	1						umberland			
			23a. Part1. Enter the disease, or com	plications that c	aused the deat	h. Do not ent	-						1110 2	Approximate
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Theu	inum	<u>a</u>								Interval Between Onset and Death
	Examiner			Due to (	or as a conseq	uence of):								(\
		Jer	Sequentially list conditions, if any leading to immediate	b. Due to (	or as a conseq	neuce of):								0
	cuted nd ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с.										
, 00,	e exe	EX	resulting in death) Last	Due to (	or as a conseq	uence of):								
8760,	icate be executed physician and s the burial-transit	dica		d										
.O. Box 6	ath certif ttending or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		irth 2 ∐ Feta ant at time of d	Ideath 3	Ectopic pre						ate of deliver	ery Day Year
<u>م</u>	res that the de signed by the a be detached t		9 ☐ Unknown  Part II. Other significant conditions o	ontributing to de	ath heit not rac	ulting in the u	nderking es	use dive	n in Part I		23a Did tol	nacco usa con	tribute to t	he cause of death?
ords,	w requires t been signe should be c	ted by	Recent wosep	8is (	Unhei	mer	s d	lew	en	ia		s 2 No		pably 4 Unknown
of Vital Records,		Completed	SPG. I ble	rediv	1-1-4	7/10	29	opl	ragi	tis	24a. Was a autops perform	y	prior to co death?	opsy findings available impletion of cause of
Vita	ician Sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:	)			Otho		of Death	(Check only on	θ)		-
ot	Phys this ral dir	2	1 ☐ Yes 2 No  27. Manner of Death	1 ☐ le		ER/Outpatien 28b. Time of		A Othe Bc. Injury	48011101		ne 5 Reside			(y)
G	ding h. After fune	tion	1 ⊠Natural 5 ☐ Pending	(Mont	h, Day Year)	Injury	M	Work	an. ? es 2.⊟1		od. Describe no	w injury occu	IIAG	
Division	J or Atten after deat Director: I in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place	of Injury - At ho ng, etc. (Specif	ome, farm, stre y)				_	28f. Location (St. City or Town		ber or Rura	al Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one)  Certifying Ph		sis of examina									
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1.0			29c.	License	number		2	9d. Date signe	ed (Month,	Day, Year)
ı	2		V. A- Rane	HACIA			T	19-	151	)	A	Vau i	10 2	2005
			30. Name and address of person who	completed caus	e of death (Item	1 23a) (Type, I	Print)	. 1				· juy	J 4	.00-
	MLS			njithan.		17 Oldton		d, Cur	mberla	nd. M	ary land	21502		
	Sta		31. Date filed (Month, Day, Year)		egistrar's Signa		esta s			,				
	Registr	ar	MINI TO SAA	J Jacoby	a dicall world	128	-							

			Please  1 - For State Registrar  1. Decedent's Name (First, Middle, L	State of Maryla	nd / Dep		Health and	Mental Hyg	iène () E	5 17127
	Physici /Medic	cal	Mildred Cathle  4a. Facility Name (If not institution, g.	en King		4h City Tour	or Location of Deal	Month O 5	Day	Yeer 3. Time of Death
	Examir	ner	Lion's Manor N			Cumberl		in		gany
	Funeral Director		5. Social Security Number 6. 212-32-8051  Usual Residence of Decedent	Sex 1 M 2 F 7. Age (In yrs	s. <i>last birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) 931	9. Birthplace (State or Foreign Country) Maryland
Maryland	e-f show	ctor	10a. State 10b. County  MD Allega		City, Town or Lo Lersli					10d. Inside City Limits 1 □Xes 2 □ No
ith with the	23a or 28 usi be no	Funeral Director	10e. Street and Number 14300 Nuthatch D	rive		10f. Zip Code 21529		10	og. Citizen of USA	What Country?
U KIKIO-UUSO filed within 72 hours after death with the Maryland	if Health and Mental Hygiene. item 27 is marked other than "neturel", or items 23a or 28e-f show other traumatic event, the Mestical Examinar must be rediffied at	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?  1		Was Decedent of Hilf Yes, specify Cubin	Hispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		ce - American Indian, ick, White, etc.  White
72 ho	"natur	Completed	15. Decedent's I (Specify only highest g	Education rade completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NDT use retired	pation during most of wo	rking	16b. Kind of B	dusiness/Industry
Mthir	r then	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	Homen		a)		Own h	.ome
aryland a should be filed	Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Las George Lester Co				Anna B.		faiden Suman	пе)
, Mar and 2 sho	ealth and n 27 Is m ser traum		19a. Informant's Name/Relationship David R. King		12329	9 Boncres	and Number or Ri t Drive,	ural Route Number, Reisters	town,	MD 21136
Dallinore Dermit. Pages 1	Depertment of Heali Importent: If item 2 any Injury or other 200ce.		20a. Method of Disposition  1 Burial Z Cremation 3  4 Donation S Other (Spec	Removal from State	cemetery, crei	osition (Name of matory or other place on Memori			avale,	- City or Town, State  MD 21502
Darit.	Depen Import any In		21. Sign store of uneral Since Lice	ensee		2. Name and Addre Harvey H.		FH, 169	Claren	ce St., Hyndman
/[	ysician Vedical		23a Part 1. Enter the disease, of control of the co	mplications that caused the decrease on each line.  a. Mcta salt  Due to (or as a conse	e Lu		ng, such as cardian		st,	Approximate Interval Between Onset and Death  M. M. M.
be executed	sician and Missis Sourial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Inceed of Injury) that initiated events resulting in death) Last	b. Due to (or as a conse						P
LIVISION OF VICES THE PROCESSION OF THE PAY FOUNDS, F.O. DOA OOF	been signed by the attending phy: should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fel 4 Pregnant at time of 9 Unknown	al death 3	⊒Ectopic pregnancy ∃ Other <i>(specify)</i>	,			ite of delivery onth Day Year
quires that t	n signed by uld be deta	þ	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tob		tribute to the cause of death?
The law requir	cete has been si , page 2 should	Completed						24a. Was an autopsy perform	ed?	Were autopsy findings available prior to completion of cause of death?  1 Yes 254No
VII.c	certifi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No	Hospital: 1 ☐ Inpatient 2 [	☐ ER/Outpatier	nt 3 DOA Oth		ath (Check only one		or (Conside)
nding Phy	within 24 hours after death,  10 the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	<del>-</del>	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injur		28d. Describe how		
lel or Atte	s after des al Director ad in by th	Certification:	3 ☐ Suicide 6 ☐ Could not determined		home, farm, str	eet, factory, office		28f. Location (Str. City or Town,	eet and Numb State)	per or Rural Route Number,
e Hospit	a 24 hour le Funere letely fills	edical (	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	Physicien: To the best of my kreminer: On the basis of examinand manner stated.	nowledge, death nation and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	, and due to the caured at the time, da	use(s) and ma te and place,	anner as stated. and due to the cause(s)
Toth	To the	M	29b. Signature and title of certifier	0		29c. Licens	_	29	d. Date signed	d (Month, Day, Year)
	6		30. Name and address of person who	ocompleted cause of death (Ite	em 23a) (Type		3280		May	0,2003
7	100		Sunil K. G	rupta - 62	5 Ken	+ Ave.	cumb	er land,	MD	21502
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 9 2	32 Aegistrar's Sigr	nature	cili				

James Lomax	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the P. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-any Injury or other traumatic event, the Medical Explant.
		Physicia /Medic Examin
	Division of Vital Records, P.O. Box 68760,	al or Attending Physician: The law requires that the death certificate be executed a after death.  I Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit.

			1 - For State Registrar	State of Ma	aryland /		artment of F <i>tificate of</i>	lealth and N <i>Death</i>	/lental Hy	giene Reg. No	20115	171	2 8
	Physici	an	1. Decedent's Name (First, Middle, La						2. Date of De Month	ath Da	y Year	3. Time of Dea	
	/Medic	al	JAMES OLIVER LO						May	04	9002		) M
	Examin	er	4a. Facility Name (If not institution, give Memorial	HOSPU	2 .		4b. City, Town, o	r Location of Death Ston		40.	County of Dear		
	Funeral Director		5. Social Security Number 6. S 214-34-5051		e (in yrs. last t	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Da MAR 20	ay, Year)	9. Birt	hplace (State or Fountry)	reigr
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Li	mits
	Many -f sho	ţō	MD TALBO	OΤ	Т	RAPE	Æ					1 <b>X</b> Yes 2 □	
	th the	Director	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What Co	untry?	
	ath wi	rai	4305 OCEAN GATE	YAW				21673			USA		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination that it willied at ODEs.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Dates:			Vas Decedent of H f Yes, specify Cuba □ Yes 2ሺ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	>-	14. Race - Ame Black, White Specify:		
50	72 ho natur	etec	15. Decedent's E (Specify only highest gra	ducation ade completed)	16	(Give	lent's Usual Occup	during most of work	ring	16b. K	ind of Business/	Industry	
12	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. L	OO NOT use retired	d)		DC	NOT GOVE	. / 3777	
2	be filed ital Hygle of other event, L		10 17. Father's Name (First, Middle, Last				LABORER	18. Mother's Name	e (First, Middle		OOL COMP	ANY	_
<u>a</u> n	uld be dental rked tic ev	To Be	GEORGE OLIVER	LOMAX				MARGARE	T BRAME	LE			
lary	2 should and Men Is marke aumatic	1	19a. Informant's Name/Relationship (	Type, Print)	19	b. Mailin	g Address (Street	and Number or Run	al Route Numb	er, City o	or Town, State, 2	Zip Code)	
	and 2 ealth m 27		MARY E. LOMAX/WII	?E				GATEWAY,		MD	21601		
altimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place cemet	of Dispo	sition (Name of natory or other plac	ce)	Date	20c. Lo	ocation - City or	Town, State	
	it. Pa irtmen irtant: njury		<ul><li>'4 □ Donation 5 □ Other (Special</li><li>21. Signature of Funeral Service Lice</li></ul>		CHESA			ION CTR 5	<b>-</b> 6-2005	SI	EVENSVI	LLE, MD	
Ba	permit. Departr Imports any Inj		Joseph 31. Ust	rough C. 1	C.S.P.	FE 20	O S. HAR	ELFENBEIN RISON ST	EASTON.	$_{\rm MD}$	UNERAL 21601	номе ра	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	I the death. Do ne.	not ente	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Deat	1
,	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				cardio	rascalar	- gis	200	و	chron.	
	Examiner		1	Due to (or as	a consequence	e of):						A 6d AZ	
	. 1	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as	a consequence	e of):							
	tificate be executed ig physician and as the burial-transit	Examiner	that initiated events	С.									
Ö,	e execian a	EX	resulting in death) Last	Due to (or as	a consequence	9 of):							
68760,	cate b	edicai	•	d									
	certifi Iding		IF FEMALE:	23c. If yes, outcome	of pregnancy					1	nod Data of dall		
P.O. Box	The law requires that the death cert ate has been signed by the attendin page 2 should be detached for use	Completed by Physiclan/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal deal		Ectopic pregnancy Other (specify)				23d. Date of deli Month	very Day Year	
S,	as tha gned be det	by P	Part II. Other significant conditions of			in the un	derlying cause givi	en in Part I.	23e. Did t	obacco u	se contribute to	the cause of death	?
ord	equir sen si ould l	ted	cigarette	2 MGK	· ng				10	/es 2[	□No 3 Pro	bably 4 Unkno	own
II Records,	The la	Comple							24a. Was autor perfo 1 Yes		prior to c death?	topsy findings avails ompletion of cause 2 No	of
Vita	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Death	h (Check only o	ne)			
o	Phy this ral d	. To	1 Yes 2 No  27. Manner of Death	1 ☐ Inpatie		outpatient Time of		4 🗆 Ivulailig Hol	me 5 Resident			rfy)	
OU	th. : After	ition	1 Natural 5 Pending 2 Accident investigation	(Month, Day		Injury	28c. Injury Work	(? Yes 2 □ No	200. Describe	iow iriqui	y occurred		
Division	or At	ertification:	3 Suicide 6 Could not b determined		ury - At home, to: (Specify)	farm, stre	et, factory, office		28f. Location (S City or Tox	Street and vn, State	d Number or Ru	ral Route Number,	
_	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	edical C	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exar	ysician: To the best on niner: On the basis of and manner sta	examination a	ge, death ind/or inv	occurred at the timestigation, in my op	ne, date and place, pinion, death occurr	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
	within To th comp	Me	29b. Signature and title of certifier	Mart		•	29c. License	number			e signed (Month		
_			Shomas.	Hellice	evs 1	X	Da	5287		0;	5104	12005	•
0	+VA)		30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, F	Print) THOME ASTON	MAS GO	1601				
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature	1 /	to the						
			1416.4.1		-	157	CONTRACTOR OF THE STATE OF THE						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1:57<sub>A</sub> 2005 MARY BOTHWELL LUCAS MAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT HEARTFIELDS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F Months 81 Director 266-26-2091 FLORÍDA JULY 15 1923 Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examinar must be notified at 1XYes 2□No EASTON Director MD TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 PORT STREET 21601 by Funeral death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinat 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HARPER BOTHWELL EUNICE JONES ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EVAN B. LUCAS/SON 25670 HERRING LANE, DENTON, MD 21629 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATION CTR 5-3-2005 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Fa FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 MERCERON JOHN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) im balance Physician electrolyte /Medical Due to (or as a consequence of): week Examiner dehidration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner 2 weeks the attending physician and hed for use as the burial-transit the death certificate be executed thrive to tailure Due to (or as a consequence of): 3 months P.O. Box 68760. advancin dementio Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð none 1 🗌 Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed/ 2 No 1 Yes 2 No 1 TYes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one ASSISTED Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) AXOther (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this LIVING 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident s after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel within 24 hours a

To the Funerel I

completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 3, 2005 Commerce Dr., Str. 106, Easton, MD 21601 30. Name and address of person who completed cause of death (Item 23a) Type, Print)
ITWIN ALLEN WEDD, Jr., M.D., 8579 Com (10 31. Date filed (Month, Pay, 32. Fingistrar's Signature 0 4 2005 State Registrar

	1	For State Registrar	State of Maryland		rtment of H tificate of L			eg. No. 200	5 17131
Physician	1	Decedent's Name (First, Middle, Last)  John	Lewis		Loar		2. Date of Death	h Day Year 4 ZOO	3. Time of Death
/Medical Examiner Funeral Director	5	. Social Security Number 6. Sex	PTAL  7. Age (In yrs. ia	ast birthday) Yrs.		ERLAN If Under 24 Hrs. Hours Min.		4c. County of Dea	ith
ט	1	Joual Residence of Decedent  Oa. State 10b. County  PA Bedford	10c. City,	, Town or Loc			02/14/172		10d. Inside City Limits 1 ☐ Yes 2 ☒ No
with the Mar 3s or 28e-f sl		Oe. Street and Number  Route 1 (Palo Alto F	(ned)		10f. Zip Code	45	10	0g. Citizen of What C	ountry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23s or 28e-f show any injury or other treumatic event, the Medicul Exartinar invalue routiles at once.  To Be Completed by Europe 1 Director	2		. Was Decedent Ever in U.S Armed Forces? 1 ☑Yes 2 ☐ No 1942- If Yes, Give	- If	Vas Decedent of Hi	spanic Origin? (Spin, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	ite, etc.
thin 72 hour e. An "natural" Medicul Ex	Completed by	15. Decedent's Educe (Specify only highest grade Elementary/Secondary (0-12)	tion	(Give I	ent's Usual Occupa kind of work done of OO NOT use retired	luring most of work	ing	16b. Kind of Business	,
ntal Hygien ed other th	9 1	7. Father's Name (First, Middle, Last)	F.	Loar	Laborer	18. Mother's Name			ery ridges
nd 2 should th and Mei 27 is marki treumatic	0	James 19a. Informant's Name/Relationship (Type John 0. Loar / son		19b. Mailin		and Number or Rura	al Route Number,	City or Town, State,	
Pages 1 an ent of Heal nt: If item 2 ry or other	2	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Re  '4 ☐ Donation 5 ☐ Other (Specify)	moval from State	ace of Dispos emetery, crem	sition (Name of natory or other place Crematory		Date	20c. Location - City o	
permit. Departm Importe any inju		21. Signature of Funeral Service Licensee			. Name and Addres		*	Funeral Hom nd, Maryland	·
-nysician /Medical Examiner		23a. Pan1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death cause on each line.  iVV Sep  Due to (or as a cons yu	515	er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death  3 day
cate be executed physician and the burial-transit	E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ			42 64			
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ial or Attendii s after death. al Director: A ed in by the fu	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (St City or Town	treet and Number or F n, State)	Rural Route Number,
n 24 hour he Funeri pletely fill	edical	(Check only 2 Medical Exeminone)	cian: To the best of my know er: On the basis of examinat and manner stated.	wledge, death tion and/or inv	vestigation, in my o	pinion, death occur	red at the time, d	ate and place, and du	e to the cause(s)
	2	29b. Signature and title of certifier	m.D.		29c. Licens	56207		9d. Date signed (Moi	2.005
2/1UA									

		State of		Depa	artment of H	ealth and M	•		) 5 17101
		State Registrar		Ce	rtificate of L	Death	F	Reg. No.	00 1/131
0		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ith Day	3. Time of Death
Physic /Medi		Dolores J. Lees					05		05 13:35 M
Exami		4a. Facility Name (If not institution, give street and numb			0 1	Location of Death		4c. County	of Death
		Sacred Heart Ho	spital		Cumb			Alleg	gany
Funeral			Age (In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year)	Birthplace (State or Foreign Country)
Director		213 22 4396 1 <sup>1</sup> M <sup>2</sup> V F	78	Yrs.			3-17-1	927	PA
pu .		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wm or Lo	ocation				10d. Inside City Limits
aryle sho	=	PA Bedford	Hyndma		oution.				1⊠Yes 2 □ No
he M	Director	0	Hyrama	LYL	101 7: 0:1:			10 0 0 11 1 14	
with t	Dir	10e. Street and Number			10f. Zip Code			10g. Citizen of W	rnat Country?
be filed within 72 hours after death with the Maryland lat Hygiene. Id Hygiene. Id other than "natural", or Items 23a or 28a-1 show event, I're Madical Exeminer mast be notified at	Funerai	172 Water Street	and Sugar in 11 C	12	15545	annia Origina (Soc	noite Van au Na	USA	- American Indian,
er de Item Cert	nu	Armed Ford		13.	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black	k, White, etc.
rs aft	by F	1 Never Married 2 Married 1 Yes 2 If Yes, Give 3 Widowed 4 Divorced Year or Dat	XINO		1□Yes 2以No	Specify:		Specify.	: White
Thou hou	ed t	15. Decedent's Education		a Dece	dent's Usual Occupa	ition		16b. Kind of Bu	siness/industry
in 72	Completed	(Specify only highest grade completed)		(Give	kind of work done of DO NOT use retired	luring most of worki	ng		on our modelly
with with the the	I E	Elementary/Secondary (0-12) College (1-4		lerl	, ,			Railro	7 d
Hygi Hygi		17. Father's Name (First, Middle, Last)		LULI	٠	18. Mother's Name	(First, Middle,		
d be ontal	To Be	Henry Allen Temke				Maude El	izaheth	Bruch	
Mal y fall of 1.2. 12 should be filed within hand Mental Hygiene. 7 is marked other than traumatic event, It a M.	Ě	19a. Informant's Name/Relationship (Type, Print)	19	b. Maili	ng Address (Street a				State, Zip Code)
ie, intal ylatification with in 72-0000 s 1 and 2 should be filed within 72 hours after death with the Marylar Health and Mental Hygiene. item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, II to Modical Executions to incition at		James J. Lees, Jr., spou			Box 254			5545	
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Pages nent of I int: If it		1X Burial 2 Cremation 3 X Removal from Si			matory or other place Cemetery		-2005	Bullage	Mills, PA
		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Ocensee	maac		2. Name and Addres		-2003	buyyacc	Wills, PA
Dall Permit. Departi Importa any Inj		21. Signature of Fundamental Service Services		He	viveu H. Z	eigler F	uneral t	tome He	Indman, PA
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Physician /Medical Examiner		23a. Parts Enter the disease, or complications that can shock the heart failure. List any one rause on ear Immediate Cause (Final disease or condition resulting in death)  a	ch line.	nyo	ocardia	/ In/	Gartre		Interval Between Onset and Death UNK nown
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	r as a consequence	e of):					
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nd ph	Med	IF FEMALE:							
The Loud us, T.C. DOX 00100,  The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	23b. Was decedent pregnant 1 Live bir	ome of pregnancy th 2 ☐ Fetal deat nt at time of death m		Ectopic pregnancy Other (specify)			23d. Date Mor	e of delivery hth Day Year
that the by deta		Part II. Other significant conditions contributing to dea	th but not resulting	in the u	inderlying cause give	en in Part I.	23e. Did to	bacco use contr	ibute to the cause of death?
requires tha	d by						1 □ Y	es 2 🗆 No	3 ☐ Probably 4 ☐Linknown
w require been si should t	ompieted						Odo Mino	-   04h 14	Mara autopou findiana available
e law has l	npi						24a. Was a autop	sy p	Vere autopsy findings available rior to completion of cause of eath?
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Vital net victan: The lay certificate has rector, page 2	Be	25. Was case referred to medical examiner?			Otho	26. Place of Death	(Check only or	18)	
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l or Attendation of the Court o	Certification:	determined 200. Flace C	f Injury - At home, g, etc. (Specify)	rarm, st	reet, ractory, office		City or Tow		or or nural noute (vuriber,
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To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Med	29b. Signature and title of certifier	Janes.	.1	29c. License	number		29d. Date sighed	(Month, Day, Year)
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10		Inous, To	71000	ny		>>/5	7	2/10	cland up
nks		30. Name and address of person who completed cause	of death (Item 23a	i) (Type,	Print) 10	COL	1.1	unha	dand um
		31. Date filed (Manyla Rev. Year) 37.	nistrar's Signature	1)	916	SCION	UN CO	11/100	1900 (111)
St Regis	ate trar	MAY 1 U 2005	gistrar's Signature	A	mile				

			For State Registrar	State of M	-		artment			and M		giene	005	171	32
			Decedent's Name (First, Middle, Last)								2. Date of De.	ath	V	3. Time of	Death
	Physicia /Medic		Harry 1	D. Magui:	re, Sr.						May	3	2005°	0930	АМ
	Examin		4a. Facility Name (If not institution, give s	treet and number)			4b. City,	Town, or	Location o	f Death		1	ounty of Dea	ath	
			23 Green Street					1evi		2411			eci1		
	Funeral		5. Social Security Number 6. Sex 186	M 6075	ge (In yrs. last birt 71	thday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Bird (Month, Da SEPT 18,	h y, Year) 1033	1 0	rthplace <i>(State dountry)</i> nnsy1vai	_
	Director		Usual Residence of Decedent		/ 1			i			DIA 1 10,	, 1900	10	iiisyivai	пта
	yland yland		10a. State 10b. County		10c. City, Town	n or Lo	cation							10d. Inside C	
	a-fsl	ctor	Maryland Cecil		Ear1	evi	11e							1 ☐ Yes	2 🗓 No
	ih th	Funeral Director	10e. Street and Number				10f. Zip						en of What C		
	ath w s 23s	ral	23 Green Street			1.0		919	0.1	-1-0 (0-	-14 - V N -		ited S		
	er de Itams	nue	11. Marital Status  1 □ Never Married 2 Married	<ol> <li>Was Decedent Armed Forces:</li> <li>1 Mayes 2 ☐ If Yes, Give</li> </ol>	, 1955-	13.	f Yes, spec	erfy Cubai	n, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	-	Black, Wh	erican Indian, ite, etc.	
36	irs aff	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	Ĩ1956		1□Yes 2	2IX No	Specify:			5	Specify: W	hite	
21215-0036	within 72 hours after death with the Maryland ene. Itan "natural", or Itams 23a or 28a-f show he Medical Exam her must to multified at	ted	15. Decedent's Educ	ation	16a.	Dece	dent's Usua kind of wor	I Occupa	ation	of worki	na .	16b. Kin	d of Business		
215	thin 7 e. an "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or		life.	DO NOT us	e retired,	)			_			
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and	2 should be filed within 72 hours after dea and Mental Hygiene. Is markad other than "natural, or Itams aumatic avant, the Medical Examine in	Be	17. Father's Name (First, Middle, Last)	udro							(First, Middle, ice Anit				
Z	hould d Mer marks matic	ပ	Harry Joseph Mag		19h	Mailir	na Address	(Street a			Route Number			Zin Code)	
Maryland	id 2 s ith an 27 is i		Patti DeRosa/Daug				_				e City,				
ē,	s 1 ar f Hea itam othar		20a. Method of Disposition		20b. Place of					May 8				Town, State	
OE .	Page:		1 XBurial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	St. Rose				-	2005	,		land	e CILY,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is merked other than "natural; or trams 23a or 28a-f show any injury or other traumatic avant, the Madical Examinat must be inclined at once.	İ	21. Signature of Funeral Service License	е ) .	-/					y Fune	rals,_]	-			
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			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that cause e cause on each l	d the death. Do r	not ent	er the mode	e of dying	g, such as	cardiac c	r respiratory a	rrest,		Approximat Interval Bet Onset and I	ween
	Pnysician :		Immediate Cause (Final disease or condition			- ~	~1	Ca	mck	4				Orisot and	ey
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):	/							/	
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39 )	death certifical attending phy I for use as th	Physiclan/Med	IF FEMALE:												
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?		e of pregnancy 2 Fetal death at time of death		Ectopic pro					23	3d. Date of de Month		Year
0	he de / the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unknown	it time of death	3 [	J Other (sp	ecity)							
٩.	w requires that the de been signed by the should be detached	by Ph	Part II. Dther significant conditions con	tributing to death I	out not resulting in	n the u	nderlying ca	ause give	en in Part I.		23e. Did t	obacco us	e contribute	to the cause of c	teath?
ecords,	requires een sign tould be	q pa									10	Yes 2	ľNo 3□F	robably 4 🗆	Jnknown
CO	law reas bee	plet									24a. Was		24b. Were a	utopsy findings completion of c	available
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ita/	ician: Th certificate ector, pag	Be (	25. Was case referred to medical examiner?							of Death	(Check only o	one)			
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	fter	lon	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Inj (Month, Da	ay Year)	Time o njury	M Z	8c. Injury Work	/at ⟨? Yes 2. □I		28d. Describe l	now injury	occurred		1
Division	Attanding r death. actor: After by the fune	ficat	3 ☐ Suicide 6 ☐ Could not be	28e. Place of In	ijury - At home, fa	ırm, stı							Number or F	Rural Route Num	iber,
Ö	after after Dira	Certification:	4 Homicide	building, e	tc. (Specify)		,				City or To	wn, State)			
	To tha Hospital or Attandi within 24 hours after death. To tha Funeral Diractor: A completely filled in by the fu	alc	29a. Certifier 1 Certifying Phys												
	ha H in 24 iha Fu	edical	(Check only 2 Medical Examir one)	and manner s	tated		_								
	With To 1	Σ	29b. Signature and title of certifier				290	. License	number	.,		29d. Date	signed (Mor	ith, Day, Year)	
			111 Jarka	7.10				15	>/	4		1016	7/	2005	
	211		30. Name and address of person who co	mpleted cause of	death (Item 23a)	(Туре,	Print)	1.1	Run	0	he som	eak.	16.	C. F.	1/12
	Sta	to.	31. Date filed (Month, Day, Year)	2. Regist	rar's Signature	ons	100	10-1			- Japan	- 100	1104	165 - //	100,19
	Regist	-	29b. Signature and title of certifier  ###################################	Marie	. J. J.	100									

DHMH 17 Rev 1/2001

PERRY

EIMARD

			1 - State of Maryland / Departm	ent of Health and Men cate of Death	_	ene 005	17134
	0		1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		LINDA JERRY MULLIGAN	C	72 I	20 0	1:10 A M
	Examin			City, Town, or Location of Death	)	4c. County of Death	011
			Sacred Heart Hospital (	nder 1 Year   If Under 24 Hrs.   8	3	Allega	119
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U Mon	ths Days Hours Min.	Date of Birth (Month, Day, Y	rear) Cou	place (State or Foreign Intry)
			Usual Residence of Decedent	AU	G. 5,19	946 MARY	LAND
	ylanc how		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	e Ma	cto	MD ALLEGANY CUMBERLAND				1 X Yes 2 □ No
	or 28	Director		. Zip Code	10g	g. Citizen of What Cou	intry?
	s 23a		235 PACA STREET, #907	21502		U.S.A.	
	within 72 hours after death with the Maryland ene. than "neturel", or items 23a or 28a-f show its Modical Exercitational Le rodified at	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ∑Never Married 2 ☐ Married  12. Was Decedent Ever in U.S. If Yes,	ecedent of Hispanic Origin? (Specify specify Cuban, Mexican, Puerto Rica	n Yes or No- an, etc.)	14. Race - Ameri Black, White	
21215-0036	urs af	by	If Yes, Give 1 ☐ Ye 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	es 2█ No <i>Specify:</i>		Specify:	WHITE
Q 2	72 ho	Completed	15. Decedent's Education 16a. Decedent's (Specify only highest grade completed) (Give kind o	Usual Occupation  f work done during most of working	16	b. Kind of Business/I	
2	ithin Be.	nple	Elementary/Secondary (0-12) College (1-4or 5+)	OT use retired)		DECMAINS.	N 1777
	fygier her th			S & BARTENDER	ina deintata de	RESTAURA	IN.T.
anc	ntal Hed of	Be	17. Father's Name (First, Middle, Last) THOMAS W. MULLIGAN	18. Mother's Name (Fit MADALYN L			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "neturel", or items 23a or 28a-1 show any injury or other traumatic event, it is Madical Exactl at matter traumatic event, it is Madical Exactl at matter radiities at 2006.	P		iress (Street and Number or Rural Ro			n Code)
	and 2 sealth ar n 27 is			OWNING STREET, CU			502
ē,	s 1 a of Hea item othe		20a. Method of Disposition 20b. Place of Disposition	(Name of Date	-	c. Location - City or T	own, State
Ë	Pages nent of I nnt: If its ury or o		1 ABuria: 2   Cremation 3   Bernoval from State	L.GARDENS 05/18/	2005	LAVALE, M	D
Baltimore,	permit. Departn Importe any inju			e and Address of Facility	OME D	7	
<u> </u>	9 Q E # 9		GUIGY (), UNIVERS 20	PCHURCH FUNERAL H D2 GREENE STREET,	CUMBER	RLAND, MD	21502
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dying, such as cardiac or res	spiratory arrest	t,	Approximate Interval Between Qnset and Death
	Pnysician		Immediate Cause (Final disease or condition resulting in death)  a	ncer			10 years
	/Medical Examiner		Due to (or as a consequence of):	01-1-000-	- ` 0 -		3. 10.11
		ē	Sequentially list conditions, if any, leading to immediate  b. Due to (o) as a consequence of):	eural effus	IOV		ZWEEKS
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
o Î	exectan an an rial-tra	Еха	resulting in death) Last Due to (or as a consequence of):				
8760,	death certificate be executed e attending physician and nd for use as the burial-transit	dical	d				
9	ing pt	Med	IF FEMALE:				
Вох	death certific attending p	lan/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	ic pregnancy		23d. Date of deliv	ery Day Year
0	the a	Physician/Me	in the past 12 months?  1 Yes PNo 9 Unknown  9 Unknown	(specify)			
<u>а</u>	The law requires that the de ate has been signed by the a page 2 should be detached f		Part II. Other significant conditions contributing to death but not resulting in the underlyi	ng cause given in Part I.	23e. Did tobac	cco use contribute to t	he cause of death?
ds,	puires tha signed ald be de	d by			1 ☐ Yes	ØNo 3□ Pro	bably 4 Unknown
Record	tw requires s been si should b	Completed			24a. Was an	24b. Were auto	opsy findings available
Be	The lay	mo			autopsy performe 1 Yes 2		mpletion of cause of No
Vital		BeC	25. Was case referred to medical	26. Place of Death (Ch		12 103	
	Physiclen: r this certific ral director,	To	examiner?  1 Yes Hospital: patient 2 ER/Outpatient 3	DOA Other: 4 Nursing Home	5 🗌 Residenc	ce 6 □Other (Speci	fy)
n C	ding Ph J. After th funeral	on:	27. Manner of Death 28a. Date of njury (Month, Day Year) 28b. Time of Injury	Work?	. Describe how	injury occurred	
isio	or Attending after death. Director: Aftel in by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be determined elemented.	1 Yes 2 No	Location (Street	et and Number or Run	al Poute Number
Division of	i or Attenc after death Director: I in by the	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, S		a) Flodie Frances,
	Hospitel		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur	rred at the time, date and place, and	due to the caus	se(s) and manner as s	stated.
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	tion, in my opinion, death occurred at	it the time, date	and place, and due t	o the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	29c. License number 00 59479	29d	. Date signed (Month,	~
7	J		beorgettennawi, MB	- 00001979	5	119156	05
(	43		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	anualch Pa	ad, Ca	in ho. a.d	40 710-
	€ Sta	to	31. Date filed (Nonth, Day, Year)  32. Registrar's Signature	opwalsh Ro	my ca	misaxx	2002
	Registr		MAY 1 7 2005 Mayer 15 April	de			

Messick, Richard

		1 - For State Registrar			Certifica			d Mental Hy	Reg. No	2000	17135	
Physici	an	1. Decedent's Name (First, Middle,	Last)					2. Date of D Month	eath Da	y Year	3. Time of Death	
/Medic	al	RICHARD LEE N						may		2005		
Examir	er	4a. Facility Name (If not institution, Me mor) a	,	ir)	46. C	ty, Town, or	Location of De		40.	4c. County of Death Talbot		
uneral			. Sex 7. /	Age (In yrs. last b		der 1 Year	If Under 24 H	rs. 8 Date of B	irth Vans	Q Bir	thplace (State or Foreigr	
irector		214-60-8121	1 <b>∑</b> M 2□F	52	Yrs. Month	Days	Hours M	FEB 28	3 195	3 MAI	RYLAND	
M. T		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Location				_		10d. Inside City Limits	
feed a	ţo	MD TALBO	ЭT		EASTON						1. Yes 2 □ No	
Important: If item 27 is markad othar than "natural", or items 23a or 28a-f ahow any injury or othar traumatic evant, Itis Medical Examinational De notified at once.	Funeral Director	10e. Street and Number				Zip Code			10g. Cit	izen of What Co	ountry?	
23a (	alD	146 CALVERT ST.	APT. 1			21601				USA	<u> </u>	
THE PARTY	nuel	11. Marital Status	12. Was Deceder Armed Force	s?	13. Was De If Yes, s	cedent of Hi	spanic Origin? n, Mexican, Pu	(Specify Yes or N erto Rican, etc.)	0-	14. Race - Ame Black, Whit		
Same	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☒ Divorced	1 ☐ Yes 2 If Yes, Give Year or Dates	-	1 ☐ Yes	2 <b>X</b> ) No	Specify:			Specify: WI	HITE	
SILE	ted	15. Decedent's	Education		a. Decedent's U	sual Occupa	ation		16b. K	ind of Business	Andustry	
Medi	ple	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4o		(Give kind of life. DO NO)	work done d use retired,	furing most of v )	working			,	
4	Completed	12	0		CHEF					ESTAURA1	VT	
өхап	Be	17. Father's Name (First, Middle, L.	st)					Name (First, Middle		Sumame)		
natic	P <sub>L</sub>	JAMES MESSICK  19a. Informant's Name/Relationshi	(Type Print)	10	h Mailine Addr	(Ctracto		OAN HARR		T- 00-1-	7.0.41	
trau		RICHARD L. MES									TER, OK7407	
othar		20a. Method of Disposition	710K 117 DOI	20b. Place	of Disposition (f	lame of	1	Date		ocation - City or		
y or		1 Burial 2 Cremation 3		10	ery, crematory`c		1	F 6 2001	C II	1237231 (337	TIE MD	
in e		21. Signature of Funeral Service Li		CHESA			s of Facility	5-6-2005	51	EVENSVI	LLE, MD	
any ir		JOHNR	MERCE	000	FELLO	WS, HE	ELFENBE	IN & NEWN	I MAI	UNERAL	HOME PA	
e		23a. Part1. Enter the disease, or c shock, or heart failure. List o	mplications that caus	ed the death. Do	not enter the m	ode of dying	g, such as card	T EASTON	rrest,	Z10U1	Approximate Interval Between	
ian		Immediate Cause (Final disease or condition			cul (	ling	car	cenom	2		4 nsey and Death	
al		resulting in death)	Due to (or a	as a consequence		1						
er 3	_	Sequentially list conditions,	b					<u></u>				
	amine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequence	of):							
s the burial-transit	×	that initiated events resulting in death) Last	c Due to (or a	is a consequence	of):							
puris	aiE			,	,							
ES KID	edic		d									
for use as I	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom							23d. Date of del	ivery	
tached for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		2  Fetal deat at time of death	h 3 Ectopia 5 Other					Month	Day Year	
stache	hys	9 🗆 Unknown										
be det	by	Part II. Other significant condition	s contributing to death	but not resulting	in the underlying	j cause give	n in Part I.		_		the cause of death?	
should	Completed							- 10	Yes 2[	□No 3□Pr	obabiy 4  Unknown	
CVI	npie							24a. Was	psy	prior to	itopsy findings available completion of cause of	
paç	Cor							perfe 1 ☐ Yes	ormed? 2 No	death? 1 ☐ Yes	2□ No	
director,	Be	25. Was case referred to medical examiner?	Hospital:	_		Othe	in a	eath (Check only				
a	. To	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of In		utpatient 3 Time of	28c. Injury	4   Nursing	Home 5 Res			cify)	
a Tuner	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, E	Jay Year)	Injury M	Work	? ′es 2 ∐ No			, 55531104		
oy me	Certification;	3 ☐ Suicide 6 ☐ Could no	be 28e. Place of I	njury - At home, f							ıral Route Number,	
u pe	Sert	4 Homicide	building,	etc. (Specify)				City or To	wn, State,	)		
aly III.		29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the bes	st of my knowledg	e, death occurre	ed at the time	e, date and pla	ce, and due to the	cause(s)	and manner as	stated.	
completely filled in by	Medical	one)	aminer: On the basis and manner:	stated.				curred at the time,				
COL	2	29b. Signature and title of certifier	C. +0	)	2	9c. License	number 7		29d. Dat	e signed (Monti	h, Day, Year)	
		> Duna H	mun	١ .		071	00/		2/	0100	)	
	L											

Registrar
DHMH 17 Rev 1/2001

State

DAVID H. SMITH M.D.

31. Date filed (Month, Day, Year)

MAY 0 6 2005

29466 PINTAIL DR. EASTON, MD 21601
32. F distrar's Signature

			1 - State of Ma	aryland / Depa <i>Ce</i>	artment of He		nd Ment		ene) ()	95	17136
			Decedent's Name (First, Middle, Last)					ate of Death	Day	Year	3. Time of Death
	Physici /Medio		FLOYD LOVELL PETERS, J	R				RIL 2		005	20:12 M
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L	ocation of	Death		4c. County	of Death	
			MEMORIAL HOSPITAL  5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	CUMBERLAN  If Under 1 Year	D If Under 24	4 Hrs.   8 D.	ate of Birth	ALLEGA		ace (State or Foreign
Н	Funeral Director		233-50-7547 1⊠M 2□F	70 Yrs.	Months Days	Hours	Min. (A	Month, Day, Y		Count	Virginia
	pe ,		Usual Residence of Decedent	40- Oh. T.							
	shov	or	10a. State 10b. County	10c. City, Town or Lo	ocation					10	od. Inside City Limits  1   Yes 2   No
	28e-f	ect	WV MORGAN  10e. Street and Number	PAW PAW	10f. Zip Code			100	g. Citizen of W	/bat Coun	
	filed within 72 hours after death with the Maryland Hygiene. other then "neturel", or Items 23e or 28e-f show ent, the Modical Exentrant be ricilled an	Funeral Director	208 AMELIA STREET		25434				USA	.,	,
	death	nera	11. Marital Status 12. Was Decedent I Armed Forces?		Was Decedent of His If Yes, specify Cuban	panic Origi	in? (Specify \	es or No-		- America	
92	or lite	y Fu	1 Never Married 2 Married 1 Yes 2 🕅 If Yes, Give	10		Specify:	1 donto i nodin	, 0.0.,	Specify	k, White, e Wh	ite
Ş	hours turel',	ed by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education	16a Dece	dent's Usual Occupat			16			usta
5	in 72	Completed	(Specify only highest grade completed)	(Give	kind of work done du DO NOT use retired)		of working	16	ib. Kind of Bu	siness/ind	ustry
212	d with	Com	Elementary/Secondary (0-12) College (1-4or 5	+)	Laborer				_ Manuf	actu	ring
9	al Hy d other	Be	17. Father's Name (First, Middle, Last)		1	18. Mother	's Name (Firs	t, Middle, Ma	iden Sumami	9)	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 is marked other then "neturel", or items 23e or 28e-f show titem 27 is marked other then "neturel", or items 23e or 28e-f show other treumatic event, it e.M. after it error.	2	Floyd L. Peters, Sr.						ot King		
Mai	d 2 sh th and 7 Is m treum		19a. Informant's Name/Relationship (Type, Print)  Larna Powell - Daughter		ng Address <i>(Street an</i> Box 74					,	•
	of Health of Health litem 27		20a. Method of Disposition	20b. Place of Dispo	sition (Name of	1	Date	-	ginia oc. Location - (		
ē	bages ent of nt: If ii		1 Burial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)	Woodrow	matory`or other place) Cemeterv	- 1	/30/200	05 P	aw Paw	. Wes	t Virginia
altimore,	permit. Pages 1 a Department of Her Importent: if item eny injury or othe		21. Signature of Funeral Service Licensee		2. Name and Address				eral H		
m	Ped In Supposed		Kith Kiml						est Vi		.a 25434
Г			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	the death. Do not ent	ter the mode of dying,	such as ca	ardiac or resp	piratory arres	t,		Approximate Interval Between
-5	Pnysician		Immediate Cause (Final disease or condition resulting in death)  a. METASTA	FIC MELANO	MA						Onset and Death
k	/Medical Examiner		Due to (or as	a consequence of):							
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a	a consequence of):							
5	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events C.								
Ó	an an	Exe		a consequence of):							
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dlcal	d.							-	
9 xo	leath certific attending p	/Me	IF FEMALE: 23c. If yes, outcome	of pregnancy					004 8	-4-1	
00	atten atten I for u	Physician/Me	in the past 12 months?	2 Fetal death 3	Ectopic pregnancy Other (specify)				Mon	of deliver th	y Day Year
o.	that the dened by the a	hysi	1 Yes 2 No 9 Unknown								
o,	ss tha gned I	by P	Part II. Other significant conditions contributing to death be	ut not resulting in the u	nderlying cause given	in Part I.	2				e cause of death?
ord	w requires to been signer should be	ted	MULTIPLE MYELOMA					1 🗌 Yes	2 🗆 No	3 🗌 Proba	ibly 4 🗹 Unknown
Records,	e law r has be je 2 sh	Completed					2	4a. Was an autopsy	l pi	rior to com	sy findings available ipletion of cause of
							1	performe □ Yes 2 2		eath?	2□ No
Vita	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?		Other		of Death (Che				_
ō	Phys r this aral di	): To	1 Yes 2 No 1 Inpatie  27. Manner of Death 1 Natural 5 Pending (Month, Day)		f 28c. Injury a	at			e 6 □Othe		)
o	Attending Physicien: r death. sctor: After this certific by the funeral director,	atlor	1 ☑Natural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	Year) Injury	Work?	es 2No	0				
Division of	f or Attencatter death Director:	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e. Place of Inju	ury - At home, farm, str	reet, factory, office		28f. L	ocation (Stre	et and Numbe State)	r or Aural	Route Number,
	itef or A irs after rel Dire	Cer					Ц				
	Hospite 24 hours Funerel stely filled	Medical	29a. Certifier 1 Certifying Physician: To the best of (Check only one) 2 Medical Examiner: On the basis of and manner sta	examination and/or in	h occurred at the time vestigation, in my opir	, date and nion, death	place, and di occurred at	ue to the caus the time, date	se(s) and mar a and place, a	ner as sta nd due to	ited. the cause(s)
	To the Hospitef within 24 hours a To the Funerel Completely filled	Mec	one) and manner sta	rou.	29c. License i	number	_	29d	Date signed	(Month, D	Pay, Year)
	6		Julia	_	D	22200			torie :		2005
٠	D.B.		30. Name and address of person who completed cause of de	eath (Item 23a) (Type,		33280		-		10,	
	nus		GUPTA, SUNIL K., M.D., 625	KENT AVENU	E, SUITE	101,	CUMBER	LAND,	MD 215	02	
	Sta	- 4	31. Date filed (Month, Day, Year)  MAY 1 7 2005	ar's Signature	ريخ						
	Registr	ar	MINI TI COOD BREED	2.3							

Completed by	Dementra					1 <b>K</b> Ye	es 2□No	3 ☐ Pro	bably 4 Unknown
by Phy	Part II. Other significant conditions	econtributing to death but no	t resulting in the u	underlying cause giver	ı in Part I.	23e. Did tob	pacco use c	ontribute to	the cause of death?
Physician/Medlo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	Fetal death 3[	□Ectopic pregnancy □ Other (specify)				Date of deliving	very Day Year
cal Examiner	Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cor							
	23a. Part 1 Enter he disea co shock or leart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. End S  Due to (or as a cor  Par' I wo	tage	Emphyse Thrive	, such as cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death Years Weele
	21. Signature of Funeral Service Lie	kithe	R	2. Name and Address icketts Fu	meral Ho	me Myer	rsvill	Stree le, MD	21773
ľ	1 X Burial 2 □ Cremation 3 1 Under Specific Spe	cify)	Resthave	nmatory or other place n Mem Gdns	5-17-				Maryland
	Doris Grossnick  20a. Method of Disposition		0b. Place of Disp	3 Wolfsvil osition (Name of	D			Mary1:	
To	19a. Informant's Name/Relationship		19b. Maili	ing Address (Street ar			, City or To	wn, State, Zi	ip Code)
Bec	17. Father's Name (First, Middle, Las Roy Edward Ripp				18. Mother's Name Rennie		Maiden Sun	name)	
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired) tenance			City	of Fr	ederick
To Be Completed by Funeral Director	3 ☐ Widowed 4 ☒ Divorced  15. Decedent's (Specify only highest g	Year or Dates:	(Give	edent's Usual Occupate kind of work done du	ion	ng		f Business/li	
Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	#1 O.S. 13.	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 ☒ No	, Mexican, Puerto I	Rican, etc.)	E	Race - Amer Black, White ecity: Wh:	, etc.
Funeral Director	10549 Highland S			21773			US		
rect	Maryland Frede:	EICK	Myersvi	10f. Zip Code		1	0g. Citizen	of What Cou	
'n	10a. State 10b. County		City, Town or L						10d. Inside City Limit
	Usual Residence of Decedent	01			¥	Aug. 4,	1923	Mar	yland
!		100 M 20 F	yrs. last birthday, Yrs.	If Under 1 Year     Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birth Cou	place (State or Foreigntry)
ner	Northhampton M		Home	Freder				ederi	
	ROY E.  4a. Facility Name (If not institution, g	DWARD RIPPEO ive street and number)	N, JR.	4b. City, Town, or I	ocation of Death	May	15 4c. Cou	2005 inty of Death	3:50 a.
ian cal	Decedent's Name (First, Middle, L					2. Date of Deat Month	Day	Year	3. Time of Death

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, <

			State	e of Maryland / (	Department of F Certificate of	lealth and M	ental Hygie	•	17138
			Registrar		Cortinoato or	J 0 4 1 1 1	2. Date of Death	. 140.	3. Time of Death
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Frances Virginia				Month May	Day Year 5 200	5 2116 PM
	Examin	er	4a. Facility Name (If not institution, give street and	, li \	4b. City, Town, o	r Location of Death	3	4c. County of Dea	1
			Dorchester Gene		tal Ca	mbridge			1ester
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☑ 6. Sex	7. Age (In yrs. last bii F 91	Yrs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y July 15,	9. Bir 1913 Ma	thplace (State or Foreign ountry) aryland
	pu ,		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	m or Location				10d. Inside City Limits
)	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  See or 28s-f show many injury or other traumatic event, it a Modical Examinator usit to notified a spice.	tor	MD Dorchester	Too. Oily, Tow		ridge			1 XYes 2 No
)	1 the	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What C	ountry?
2	38 o	0	712 Meadow Ave.			21613		USA	
)	deatl	ere	11. Marital Status 12. Was I	Decedent Ever in U.S.	13. Was Decedent of H	lispanic Origin? (Spe	city Yes or No-	14. Race - Amo	
0	rite	Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Y	d Forces? es 2 X No			Hican, etc.)	Black, Whi	
ဗ္ဗ	urs a	þ	3 ⊠Widowed 4 □ Divorced Year	, Give or Dates:	1 ☐ Yes 2 🗷 No	Specify:		Specify: V	white
P	2 ho	ted	15. Decedent's Education		. Decedent's Usual Occup (Give kind of work done	pation	16	b. Kind of Business	/Industry
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2	d wit	Completed	6		presse	r		laundry	
덛	othe vent,	ВеС	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Ma	iden Sumame)	
<u> </u>	Abnta Abnta rked tic e	ToE	Grafton W. Slacum			Essie G	reenwell		
Maryland 21215-0036	should had a man	-	19a. Informant's Name/Relationship (Type, Print)	196	. Mailing Address (Street	and Number or Rura	l Route Number, C	City or Town, State,	Zip Code)
Ž	alth a 27 ls		Elizabeth Willey	sister	712 Meadow A	ve., Camb	ridge, MD	21613	
ō,	s 1 a f Hea item othe		20a. Method of Disposition	20b. Place o	f Disposition (Name of ry, crematory or other pla			c. Location - City or	Town, State
٦ و	age ent o ent : If nt: If y or		1   Burial 2 □ Cremation 3 □ Removal fi  4 □ Donation 5 □ Other (Specify)	UIII State	New Market C		0/05 E	ast New M	Market, MD
Baltimore,	artm crtar cortar injur		21. Signature of Funeral Service Licensee		22. Name and Addre			neral Hon	
Ba	Dept Dept Impo any i		BirkR		700 Locus	t St., Car			
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause	nat caused the death. Do					Approximate
			shock, or heart failure. List only one cause Immediate Cause (Final	on each line.	T C!				Interval Between Onset and Death
	Physician /Medical		disease or condition	Typicardial	Infarcti	90			
	Examiner		Due	e to (or as a consequence	1	0	,		
н		_	Sequentially list conditions,	t ras a consequence		Preumon	19		
	ed isit	line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		017.				
	and I-trar	Examiner	that initiated events C.	to (or as a consequence	of):				
760,	eath certificate be executed attending physician and for use as the burial-transit	calE			•				
687	phys the		d						
9 ×	ding se as	by Physician/Medi	IF FEMALE: 23c If yes	, outcome of pregnancy				22d Date of de	li sono s
Вох	atten for u	lan	in the past 12 months?	ive birth 2  Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	У		23d. Date of de Month	Day Year
o.	res that the de signed by the a I be detached f	ysic		Inknown	3 Other (specify)				
٥.	hat thid by	Ph	Part II. Other significant conditions contributing	to death but not resulting i	in the underlying cause giv	ven in Part I	23e. Did tobar	cco use contribute to	o the cause of death?
Vital Records,	The taw requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	by	,	,	, , , , , , , , , , , , , , , , , , ,		1 □ Yes	2 □ No 3 □ P	robably 4 Qunknown
Ö	w require been si should b	etec							
ec	e taw has b	Completed	<u> </u>				24a. Was an autopsy	prior to	utopsy findings available completion of cause of
=		So					performe 1 □ Yes 2 □		2 □ No
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			26. Place of Death	(Check only one)		-
	Physi this c	P		1 Inpatient 2 ER/O		4   Nursing Hor		e 6 □Other (Spe	ocify)
	ding P h. After t funera	ü	27, Manner of Death  1 Natural 5 Pending		Time of 28c. Injury Wo	rk?	28d. Describe how	injury occurred	
Division of	Attending Physician: The sr death. sctor: After this certificate he by the funeral director, page	Certification;	2 Accident investigation			Yes 2 □ No			
Ξ	ter d iract iract	Ħ	determined 286. P	lace of Injury - At home, Is uilding, etc. (Specify)	arm, street, factory, office	1	28t. Location (Stree City or Town, S	et and Number or R State)	ural Route Number,
	To the Hospitel or Attending Physician: within 24 hours after deals to the Funerel Director. After this certific completely filled in by the funeral director,								
	Hosp 4 hou Fune ely fi	Medical	29a. Certifier 1 Certifying Physician: To 2 Medical Examiner: On the	he basis of examination ar	e, death occurred at the ti nd/or investigation, in my d	me, date and place, a opinion, death occurre	and due to the cau: ed at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	the fring the fundamental the	led		manner stated.	-ma line		204	Data signed (Man	th Carr Vacal
	Son To Property	2	29b. Signature and title of certifler	15 A 1 1	1 29c. Licens	50 E (827		. Date signed (Moni	
			· w!/00	0000		_	1		
		1	30. Name and address of person the completed	cause of death (Item 23a)	(Type, Print) 7 Bun	vSt. C.	ambridae	MD 2161	3
					302 0911	, ca	a.w. rage,	ا ۱ ا ا	
	Sta		31. Date filed (Month, Day, Year)  MAY 0 9 200	32. Registrar's Signature	n Ante				
	Registr	ar	mn1 0 0 200.	All Backer of	CO DESIGNATION				

			1- State of Maryland Registrar	-	artment of He tificate of D			Reg. No.	15 17130
	Physici /Medi		Decedent's Name (First, Middle, Last)     Mildred M. Steele				2. Date of De Month	Day / 3	Year 2005 7:10 P M
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo	ocation of Deat	h J	4c. County	//
	Funeval		5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthdav)	If Under 1 Year	C/C If Under 24 Hrs	8. Date of Bir	h	9. Birthplace (State or Foreign
	Funeral Director		214-26-2170 1 M 2 H F 74	Yrs.		Hours Min.	09/29/1	930 930	Maryland
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, T	own or Lo	cation				10d. Inside City Limits
	or death with the Marylar tema 23a or 28a-f show et must be mailfied at	tor	MD Harford	Aberd	<del></del> n				1¥ Yes 2 □ No
	th the	Director	10e. Street and Number	12020	10f. Zip Code			10g. Citizen of V	/hat Country?
	ath wil	raiD	700 W. Bel Air Avenue Apt. 327		21001			U.S.A.	
	after dea or Itema	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hisp f Yes, specify Cuban,	anic Origin? (S Mexican, Puerl	pecify Yes or No o Rican, etc.)	14. Race Blac	e - American Indian, k, White, etc.
) ) )	filed within 72 hours after death with the Maryland Hygiene. uthar than "natural", or tlema 23a or 28a-f show ant, the Medical Erarili wir must be medified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	☐ Yes 2XNo	Specify:		Specify	White
	"natural",	Completed	15. Decedent's Education (Specify only highest grade completed)	6a. Deced	lent's Usual Occupation	on ina most of wo	rkina	16b. Kind of Bu	siness/Industry
	d within 72 ho piene. r than "natu	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	life. D	kind of work done dur 20 NOT use retired) Hammaker		9	Llomo	
1	be filed w tal Hygier d othar th evant, IL		12 2			B. Mother's Nar	ne (First, Middle,	Home  Maiden Sumam	9)
3	d bl enta	To Be	John Thompy			Anna Ma	atthews		
	2 8 8				g Address (Street and				State, Zip Code)
ì	f Health itam 27 other tr				ndemere Dr.,	Aberdeer	n, MD 2100°		0'A - T
		li i	I Libuliai 2 Microlliation 3 Linelliovat Itulii 5tate		sition (Name of natory or other place)	5/16/		Vest Chest	City or Town, State
	- E # 5		' 4 □ Donation 5 □ Other (Specify) R.A.P.		& Company  Name and Address of			west utest	er, m
í	Depa Impo	6	Kusten A. Uneresb	Ab	rring-Cargo 1 erden, Mary	land 2100	11–3399		
	death certificate be executed  Medical Example 1 of the burial transit of the burial tra	dical Examiner	Sequentially list conditions, If any, leading to immediate course leader to lead the course of the c	SU	ndrome Parcinoic	10fs	rmall e	nowe!	Onset and Death 12 hours
	the ache	hysiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de- 4 Pregnant at time of death	ath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery th Day Year
	w requires that the sbeen signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting	g in the un	derlying cause given i	in Part I.	23e. Did to	$\sim$	bute to the cause of death?  3 Probably 4 Unknown
	The law ate has b page 2 si	Completed					24a. Was a autop perfor	sy pi męd? di	ere autopsy findings available for to completion of cause of eath?  Yes 2 No
	Physician: The Propertion of this certificate he ral director, page	Be	25. Was case referred to medical examiner?  Hospital:		Other		th (Check only or	18)	
	두 등	ation; To	TE THE TRUING I MAINPAtient 2 ERV	Outpatient b. Time of Injury	28c. Injury at Work?		ome 5 Resid 28d. Describe h	ence 6 □Othe ow injury occurre	
	To the Hospital or Attending within 24 hours after death.  To tha Funaral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)				City or Tow	n, State)	r or Rural Route Number,
	the Hosp in 24 hou the Funal pletely fill	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowled and manner stated.	dge, death and/or inv	occurred at the time, estigation, in my opini	date and place on, death occu	, and due to the c rred at the time, c	ause(s) and mar late and place, a	ner as stated. nd due to the cause(s)
	To T Com	Σ	29b. Signature and title of lertifier		29c. License no			9d. Date signed 05 / 14	(Month, Day, Year)
	4		30. Name and address of person who completed cause of death (Item 23	a) (Type, F	D-51:	a /him			
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Signature	Ana	SILVE POL	11/1/16	10,11	-125/	
	Registr	ar	MAY 2 0 2005 James A.	The same of					

05-3320 B.K.S WILLIAM STAU

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Physici	an	State Unpend Item 23 Registrar  1. Decedent's Name (First, Middle, Last) WILLIAM THEODON	2. Date of Dea	ath	Year	3. Time of Death							
/Medio	al	4a. Facility Name (If not institution, give s 1046 TANEYTOWN PIK			y of Death	1200 P M							
Funeral Director		5. Social Security Number 6. Sex		e (In yrs. last birthda 80 Yrs.		Year	TER  If Under 24 Hrs. Hours Min	s. 8. Date of Birt		9. Birthp	place (State or Foreign stry) ARYLAND		
	Director	Usual Residence of Decedent  10a. State 10b. County  MARYLAND CARROLL		10c. City, Town or WES'	ocation	ER .					0d. Inside City Limits 1 ☐ Yes 2 ☐ XIX		
with th		10e. Street and Number 1046 TANEYTOWN PIK	<u>.</u>		10f. Zip (	ode 21158	2		10g. Citizen of UNITE				
filed within 72 hours after deeth with the Maryland Hygiene. uther than "naturel", or Iteme 23a or 28a-f show ent, Ite Medical Examinar must be notified at	by Funeral		12. Was Decedent E Armed Forces? 1 ☐ Yes 2½ N If Yes, Give Year or Dates:	Ever in U.S. 13		nt of Hisp y Cuban,		Specify Yes or No- rto Rican, etc.)	14. Ra Bla	ce - Americack, White.	ean Indian, etc.		
vithin 72 hound. ne. han "nature	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		+) (Giv	DO NOT use	done du	ion uring most of wo	orking	16b. Kind of B	Business/In	dustry		
9 E 5 S	To Be Co							STATE ROADS OF MAI me (First, Middle, Maiden Surname) Y STOOPS			S OF MARYLA		
and 2 salth ar 27 is		19a. Informant's Name/Relationship (Ty) M. EDNA STAUB/WIFE	pe, Print)	104	5 TANEY	AWOT.	N PIKE,	WESTMIN	ISTER,	MD 2	1158		
permit. Pages 1 a Department of He Importent: If terr any injury or oth		20a. Method of Disposition  XXBurial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)		LAKEVIE	ematory or off MEMOR	er place)	PARK 5,	/17/2005	20c. Location SYKES		, MARYLAND		
Depa Impo any ii		21. Signature of Funeral Service License	Sulva		22. Name and MYERS-I 91 WII	URBC	RAW FUI STREET	NERAL HON	Æ, P.A INSTER,	• MD	21157		
ate be executed hysicien and he burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a consequence of):									
that the death certificated by the attending phydetached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No								ory Day Year		
w requires that the been signed by should be detact	by	Part II. Other significant conditions con	tributing to death bu	it not resulting in the	underlying ca	ıse given	n in Part I.		23e. Did tobacco use contribute to the cause of c				
ician: The law requ certificate has been ector, page 2 shoul	Completed			autop	24a. Was an autopsy forformed?  1 Yes 2 No 24b. Were autopsy finding prior to completion of death?  1 Yes 2 No 1 Yes 2 No								
ding Phys h. After this tuneral dir	ation; To Be	25. Was case referred to medical examiner? 1 Xves 2 No  27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	Home 5 Resid	th (Check only one) ome 5 Residence eXXOther (Specify) AT S 28d. Describe how injury occurred									
Hospital or Attentions after deatles Funeral Director: etally filled in by the	Certification:												
	dica	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the composition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the composition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the composition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the composition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the composition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the composition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the composition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place are composition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place are composition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place are composition of the basis of examination and or investigation or investigation of the basis of examination and or investigatio									cause(s) and manner as stated. date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)		
To the Hospitel or Al within 24 hours after or To the Funerel Direc completely filled in by	Me	29b. Signature and title of certifier	n		29c.	License r	numper MT	1.1	290. Date signe	ed (Month,	Day, Year)		

DHMH 17 Rev 1/2001

MAY 2 0 2005 Stew & Specific ORIGINAL

Dhysio	on	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Di	ay Year	3. Time of Death					
hysici Medi/		Neale Chaney Slat		APRIL 2	25, 2005	2:06P.					
Exami	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	L	c. County of Death						
		PRINCE GEORGES HOSPITAL CENTER  5. Social Security Number 6. Sex 7. Age (In yrs. last birth.	CHEVERLY  day) If Under 1 Year   If Under 24 Hrs.   1		RINCE GEO						
uneral rector		214-08-8493 1⊠ M 2□F 20 Yr	Months Days Hours Min.	B. Date of Birth (Month, Day, Year March 10, 19		lace (State or Forei itry) and					
		Usual Residence of Decedent									
show	7	10a. State 10b. County 10c. City, Town	or Location		1	0d. Inside City Lim 1 ☐ Yes 2 ☑ I					
28a-f	ecto	Maryland Saint Mary's Mechanics  10e. Street and Number	sville 10f. Zip Code	100.0	itizen of What Cour						
a or	Funeral Director			, rog. C	USA	iu y r					
ns 23	era	29300 Horse Range Farm Court  11. Marital Status  12. Was Decedent Ever in U.S.	20659  13. Was Decedent of Hispanic Origin? (Spec	as Decedent of Hispanic Origin? (Specify Yes or No-							
ar ter	F	1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto R	ican, etc.)	Black, White,						
ral, c	1 by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Whi	te					
od other than "natural", or Items 23a or 28a-1 shov event, the Medical Examinar must be nutified at	Completed	(Specify only highest grade completed) (	Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired)	d of work done during most of working							
than De Ma	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	Cadet	Mars	yland State	Police					
other ant, I	ပိ	17. Father's Name (First, Middle, Last)	18. Mother's Name			TOTICE					
Is marked other than aumatic event, the M	0	Austin Joseph Slater, Jr.	Eleanor Jo	osephine Fowler							
s mai	-		Mailing Address (Street and Number or Rural	Route Number, City	or Town, State, Zip	Code)					
7.7 T.			05 Carrie Lee Lane, Mecha	nicsville, N	Maryland 200	559					
Pages 1 and 3 nent of Health int: If item 27 iry or other tr		cemetery,	Disposition (Name of Da crematory or other place)  Apr		_ocation - City or To	wn, State					
jury o		`4 □Donation 5 □Other (Specify)	Cemetery 29,		en, Maryland	1					
Important: If i any injury or once.		21. Signature of Funeral Service Licenseen	22. Name and Address of Facility Mattingley-Gardiner Funer P.O. Box 270, Leonardtown	al Home, P.A , Maryland 2	A. 20650						
กระเด่นก		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death					
		Immediate Cause (Final disease or condition a Head 15 ft vies									
edical miner		resulting in death)  Due to (or as a consequenca of	):								
	in in	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of	b. — Due to (or as a consequence of):								
unsit	Examiner	cause. Enter Underlying Cause (Disease of Injury									
sician and burial-transit	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of									
the the	dlcal	d									
attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delive	ery						
e atte	lcla	in the past 12 months?  1 Ves 2 No 4 Pregnant at time of death	Month Day								
by the stached	hys	9 Unknown									
igned b	by	Part II. Other significant conditions contributing to death but not resulting in t	23e. Did tobacco use contribute to the cause of death  1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown								
been sig	Completed										
has 9 2	mple			24a. Was an autopsy performed?	24b. Were auto prior to cor death?	psy findings availa apletion of cause					
ate				1X Yes 2 No 11 Yes 2 No							
	o Be	25. Was case referred to medical examiner?  1 X Yes 2 □ No  Hospital: 1 □ Inpatient 2 X ER/Outp	Hospital:								
After this tuneral di	H	27. Manner of Death 28a. Date of Injury 28b. Tir	me of 28c. Injury at 28	e 5 Nesidence 3d. Describe how inju	ury occurred	\$ ,					
r: Afte	atlo	1 □Natural 5 □ Pending  3 Accident investigation 4 25 € 30.	- M 4 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 -	iver it voir	rdis mitte	o eciplina					
rector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)		Bf. Location (Street a City or Town, Sta	nd Number or Rura	Route Number,					
ed in		C.4	rept H	e all in the second	0.1	discount to a					
- =	edical	29a. Certifier (Chack only one)  1 Certifying Physicien: To the best of my knowledge, 2 Medicel Exeminer: On the basis of examination and/one)  29a. Certifier 20a. Certifier 20a. Certifi	death occurred at the time, date and place, ar for investigation, in my opinion, death occurred	nd due to the cause( d at the time, date ar	s) and manner as sind place, and due to	the cause(s)					
ne Fune Jetely fi	₹ E	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month,	Day, Year)					
To the Funerel Director: completely filled in by the				A TOTO T	TT 26 200	` F					
To the Fune completely fi		30. Name and address of person who completed cause of death (Item 23a) (T	OCME	APR.	IL 26, 200	)5					

			State of Maryland / [	•	nent of H			giene Reg. No.			
			Registrar  1. Decedent's Name (First, Middle, Last)	Corum			th 3. Time of Death				
	Physicia /Medic		Robert Lee Smith, Sr.				Month May	9, 2005			
Examir		er	4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of De			
			St. Mary's Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last bit		Jeonard Jnder 1 Year	town If Under 24 Hrs.	8. Date of Birtl	St. Man	Cy'S irthplace (State or Foreign		
	Funeral . Director		MT II OF		nths Days	Hours Min.	(Month, Day	7. 1935 V	Country)		
	pu »		Usual Residence of Decedent	an or Location					10d. Inside City Limits		
	shov	'n			1				1 ☐ Yes 2X No		
the M	28e-f	Funeral Director	Maryland St. Mary's Dray  10e. Street and Number		f. Zip Code			10g. Citizen of What (	Country?		
	3a or		17985 Cherry Field Road		20630			U.S.A.	•		
death ms 2:	death	nera	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. Was I		ispanic Origin? (S) n, Mexican, Puerto	pecify Yes or No-		nerican Indian,		
2	or ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No			Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify:	inte, 610.		
Š	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiens. Item 27 is marked other then "naturel; or items 23a or 28e-f show other traumatic event, the Medical Examinating to notified at	ed by	3 ☐ Widowed 4 X Divorced Year or Dates:  15. Decedent's Education 16a	Decedent's	Usual Occupa	ation	1	16b. Kind of Busines	nite -		
Ċ	in 72 n "na'	Completed	(Specify only highest grade completed)	(Give kind	of work done of OT use retired,	durina most of wor	king	Tob. King of Busines	amoustry		
7	d with giene er the	mo:		Sheet	Metal_	Mechanic		Fabricat	ion		
מש	be file tal Hyg d othe	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Sumame)			
N N	should tund Ment	2	James Brooks Smith			Unknow					
	12 sh h and 7 is m traum		Step-					r, City or Town, State,			
ב ב	1 and Healt Iem 2		20a Method of Disposition 20b. Place of	of Disposition	(Name of		Leonard Date	20c. Location - City of	land 20650 or Town, State		
<u> </u>	Pages nent of int: If it iry or o		1 Burial 2 Cremation 3 Hemoval from State		y or other place -Echols	1	3-05	Charlotte	Ha11. MD		
altimo	그 된 원 급		21. Signature of Euneral Gervice Licensee		ne and Addres	( F			Home, P.A.		
ŏ	Deprime any source		Colley N. D. S moss 2	P.0.	Box 2			Maryland 2			
- 145			23a. Part1. Enter the disease, or co-hplications that caused the death. Do shock, or heart failure. List only one cause on each line.						Approximate Interval Between		
i	Physician		Immediate Cause (Final disease or condition	1 am	O Circ	culaton	2 Colla	pe	Onset and Death		
	/Medical Examiner		shock, or heart failure. List on voor cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	of in	2. Len	0000014	Quali	7	38-		
		- G		of):	Or More	^	6 -	1	3 deg		
	uted 1 ansit	Examine	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	gano	renea	nd curini	any Ma	ict infect	unknown		
Ď	exect an and rial-tra		resulting in death) Last  Due to (or as a consequence	of).							
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Õ	ing ph	0	IF FEMALE:								
Z D	w requires that the death certifit been signed by the attending f should be detached for use as	clan/M	23b. Was decedent pregnant in the past 12 months?		pic pregnancy			23d. Date of d Month	elivery Day Year		
5	he de	Physic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death	5 LI Othi	er (s <i>pecify)</i>						
ř.	that the poly detail	y Ph	Part II. Other significant conditions contributing to death but not resulting	in the underly	ing cause give		)	bacco use contribute	to the cause of death?		
Hecords	law requires that the as been signed by th 2 should be detache	ed by	Renalfailure, anemia Respira		ilune,	metabo	(iC 1□Y	es 2 <b>X</b> No 3□F	Probably 4 Dunknown		
ပ္သ	aw rei Is bee 2 sho	Completed	acidosis, Abdeminal acretic and	eryfn	, kou	t kidne	24a. Was a	an 24b. Were a	autopsy findings available completion of cause of		
	The ate h page	Com	hypronephrosis, hematuria, en	apha	Lopan	7 Hepate	perfor	med? death? 2 XNo 1 ☐ Ye			
VItal	sicien: certifica irector.	Be (	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only or	ne)			
OI		10		utpatient 3	DOA Othe	+ I Nuising H		ence 6 Other (Sp	ecify)		
	ding After tune	tion	1 XNatural 5 ☐ Pending (Month, Day Year)	Injury	Work	Yes 2 □ No	280. Describe ii	be how injury occurred			
DIVISION	or Attending Phy after death. Director: After thi in by the funeral (	Certification:	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, for	arm, street, f	actory, office			treet and Number or I	Rural Route Number,		
	s after	Serti	4 ☐ Homicide determined building, etc. (Specify) City or Town, State)								
Y	To the Hospital or Al within 24 hours after of To the Funerel Direct completely filled in by		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination ar								
0	To the H within 24 To the F complete	Medical	one) and manner stated.		29c. License			29d. Date signed (Mor			
	To To Con		29b. Signature and title of certifier	D.							
			30. Name and address of person who completed cause of death (Item 23a)	(Type Print	D51	738		May 10,	2005		
			Kae T. Aung, M.D. 24435 Mervel			Hollywoo	d, Marvl	and 20636			
	Sta	ate	31 Date filed (Month, Day, Year) 32 Binistrar's Signature	_							
	Registi	rar :	MAY 1 3 2005	And the							

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ORIGINAL

	James H	• `			State of M	Marylan	•					lental Hy	giene	100	i .n.d. 1	1 0	
		_	1 - For State Registrar				Cei	rtificate	e of L	Death			Reg. No:-	CUI	1/1	43	
1	Physici	an	1. Decedent's Name (First, Middle, Last)							2. Date of De. Month	Day	Year	3. Time of	P M			
	/Medic				D SHORES	ar)		4b. City.	Town, or	Location of	of Death	May 01		nty of Death	6:27		
	Examin	er	361 Gle						ton				Tal	•			
	Funeral		5. Social Security N				last birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bird	th	9. Birthr	place (State o	r Foreign	
	Director		220-26-11		1 <b>X</b> M 2□F	72	Yrs.					DEC 7	1932	MARY	LAND		
	land w		Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or Lo	cation						1	I0d. Inside Ci	ity Limits	
	Mary a-f sh	tor	MD	LAT	BOT		EAS	TON							1 <b>X</b> □ Yes	2 🗌 No	
	within 72 hours after death with tha Maryland ene. Than "naturel", or Iteme 23a or 28a-f show re Macical Examiner must be notified at	Funeral Director	10e. Street and Nur	mber				10f. Zip	Code				10g. Citizen	of What Cour	ntry?		
	ath wi	raic	361 GLEI	BE ROAD						.601				USA			
	er de:	une	11. Marital Status	ind Warrior	12. Was Decede Armed Force 1 ☐ Yes 2	s?	.S. 13.	Was Deced If Yes, spec	ent of Hi ify Cuba	ispanic Ori n, Mexicar	gin? (Sp 1, Puerto	ecify Yes or No Rican, etc.)	- 14. F	łace - Americ Black, White,			
336	irs aft	Ď	3 Widowed	ied 2 <b>X</b> Married 4 □Divorced	If Yes, Give Year or Date			1 ☐ Yes 2	X No	Specify:			Spe	cify: WHI	TE		
21215-0036	72 hou	ted	/Sand	15. Decedent's	Education grade completed)		16a. Dece	dent's Usua	Occupa	ation	t of work	ing	16b. Kind o	f Business/In	dustry		
215	ithin 7	Completed	Elementary/Seco		College (1-4or 5+)			kind of work done during most of worki DO NOT use retired)				nig	mp ii cir	TRUCKING COMPANY			
	lled w tygier her th		9 17. Father's Name	/Eirot Middle La	0		DF	RIVER		19 Moths	or'e Nam	e (First, Middle,			MPANY		
Maryland	permit. Pages 1 and 2 should at lied within 72 hours after death with tha Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Bany injury or other traumatic event, the Macical Examiner must be notified at once.	To Be	WALTER		151)							SHARP	Walderi Suli	iaine/			
larv	2 should and Missing		19a. Informant's Na									al Route Numbe		vn, State, Zip	Code)	11000	
	1 and 2 Health tem 27	J	SHIRLEY  20a. Method of Disp		WIFE	20b. F	301 Place of Dispo			D, E.		N, MD 2		on - City or To	own State		
nor	Pages nent of h int: If Ite		1 Burial 2	☐Cremation 3	☐Removal from Sta	te	semetery, crei	matory or of	ther plac	1							
Baltimore,	artme orten injur		* 4 ☐ Donation 21. Signature of Fu			WC	22	2. Name and	d Addres	s of Facilit	tv	5-2005		N, MAF			
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ı			23a. Part1. Enter to shock, or hea	he disease, or co rt failure. List or	omplications that caus nly one cause on each	sed the deat n line.								14	Approximate Interval Bett Onset and I	ween	
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	cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events														
0	e exectian an		resulting in death)	Last		as a conseq	uence of):										
8760.	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	edicai			d			<del></del>									
9 xo	eath certific attending p	/Me	IF FEMALE:		23c. If yes, outcor	ne of pregna	ancy			,			23d	Date of delive	arv		
В	death s atter d for u	Physician/M	23b. Was deceden in the past 12 1 Tyes 2	months?	1☐Live birth 4☐Pregnant	t at time of c		□Ectopic pro □ Other <i>(sp</i> o						Month	,	Year	
P.O.	that the de ed by the detached	hys	9 🗆 Unknown		9□ Unknowr	n 										av Section	
	res that igned to be det	by P	Part II. Other signif	ficant condition	s contributing to death	h but not res	ulting in the u	nderlying ca	ause give	en in Part I			obacco use c				
ord	w requir been si should											1	Yes 2□No	3  □ Prot	ably 4 AU	Jnknown	
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al H	_ F & G											1 X Yes	rmed? 2 No	1 X Yes	2 No		
Vital	Physicien: this certific ral director,	Be	25. Was case reference examiner?  12 Yes 2 □		Hospital:		LED/O		Othe			h (Check only o		Data = 1 (Cooper)	. C	_	
of	Phys er this eral di	1; To	27. Manner of Deat		1 ☐ Inpa 28a. Date of li (Month,		ER/Outpatier 28b. Time o		8c. Injury Work	4 L NU	irsing Ho	me 5 Resident			y Scene	2	
ion	ttending F death. ctor: After / the funer	atio	1 Natural 2 Accident	5 Pending investiga		Day Year)	Injury	М		<br Yes 2 □	No						
Division	r Atte er dea recto	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 🗌 Could no determin	ad 200. Place of	Injury - At h	ome, farm, sti	reet, factory	, office			28f. Location (S City or Tox		mber or Rura	al Route Num	ber,	
	ital o urs aft rel Di										- 1						
	To the Hospital or Attending within 24 hours after deather To the Funerel Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one)		Physician: To the be caminer: On the basis and manner	s of examina										.)	
	To the To the Comple	Me	29b. Signature and	title of certifier				290	. License	number			29d. Date sig	ned (Month,	Day, Year)		
			1	7 W	, mid				OCME	C			May 0	2 2005	)		
	()				ho completed cause of	of death (Iter	n 23a) (Type,		_	-		D 1. 1		4 7	1 040	204	
	(6)		L / ✓ 31. Date filed (Mon		, m D	istrate Sign	atura 🎉	111	Per	ın Stı	reet	Balti	more,	Maryla	na 212	:UI	
	Sta Registi		2 22.0 11.00 (MOI)	MAY	0 4 2005 Regi	All	ature //	A DE		•							

State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Sweitzer, Sr. 0025 Richard Leonard /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner rumberland Heganu Heart DITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 07/14/1929 5. Social Security Number 6. Sex . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☑ M 2 ☐ F 75 Maryland Director 213-24-7454 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County in then "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Director 1 ☐ Yes 2 🕅 No Cumberland Allegany MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21502 USA 13701 Sweitzer's Lane, N.E. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 XYes 2 No 1951-If Yes, Give Year or Dates: 1953 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nati any injury or other traumatic event, the Mallox Elementary/Secondary (0-12) College (1-4 or 5+) Electric Company Equipment Operator 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pearl Jones Levi Sweitzer Inez 2 Leonard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13701 Sweitzer's Lane, N.E., Cumberland, MD 21502 Claudetta E. Sweitzer / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park ` 4 ☐ Donation 5 Other (Specify) 05/16/2005 Cumberland, Maryland 21. Signature of Puneral Service License 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, Maryland 21502 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequency Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physician and hed for use as the burial-transit certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ۵ ate has been signed page 2 should be del Part II. 7 the significant conditions contributing to grate but not reculting in t 23e. Did tobacco use pontribute to the cause of death? riving cause given in Part I. Division of Vital Records. 2 3 Probably 4 Unknown 1 Yes No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 \(\subseteq\) Yes \(2 \subseteq\) No 24a Wasan certificate has 1 Tes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tyes 1 patient 2 ☐ ER/Outpatient 3 ☐ DOA this Manner of eal 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of Hospital or Attending Pl
 A hours after death.
 Funeral Director: After ti 28d. Describe how injury occurred Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D 29a. Certifie Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner states. (Check one) 29b. Signature and 29d. Date signed (Month, Day, Year) Pag 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21205 Kichard Schmitt 900 SETON DRIVE COMBETCAND, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			T TCUSC T	State of Mary	land / I	Denartme	nt of Hea	alth and N	nental Hyd	iene		
		1	For State	State of Iviary	tana / i	Certifica				leg. No.	2000	17116
			Registrar  1. Decedent's Name (First, Middle, Last)			001111100	0, 50		2. Date of Dea			3. Time of Death
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Fune	ral	5	5. Social Security Number 6. Sex	7. Age (In	yrs. last bi	inthday) If Und	er 1 Year If	Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Yeer)	9. Birt	hplace (Stete or Foreign untry)
Direc			N/A 1X	M 2 F		Yrs.	1 1	0 06	May 4,			yland
pu ,		- 1-	Usual Residence of Decedent  10a. State 10b. County	10	c City Toy	vn or Location						10d. Inside City Limits
anyla •hov		.			o. O., 101							1 ☐ Yes 2 🗓 No
he M		Director	W Minera  10e. Street and Number	<u> </u>		Ridgeley	Zip Code	-		10a. Citiz	en of What Co	untry?
with t			Route 1 Box 105	5		101. 2	2675	:3		_	JSA	••••
ING 21213-UU30 be filed within 72 hours after death with the Maryland tal Hygiene. Adother than "natural", or flems 23a or 28a-1 ehow	T. C.	Funerai		12. Was Decedent Ever	in U.S.	13. Was Dec			pecify Yes or No- Rican, etc.)		4. Race - Ame	rican Indian,
fter d		5	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 2 No					Rican, etc.)		Black, White	e, etc.
OUSO hours after tural; or ite		Ď	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	21 No S	Specify:			Specify:	White
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within 72 ene.		ᇍ	Elementary/Secondary (0-12)	Coltege (1-4or 5+)				ng most of worl				
filed without the three		S	0	0		Int	ant	Matharia Nam	ie (First, Middle,	Maidan 6	None	
land		Be	17. Father's Name (First, Middle, Last)  Israel S	hannon	Sible	37		Angela		helle	Car	·¹or
aryla should and Men	a constant	2	19a. Informant's Name/Relationship (Ty)						ral Route Numbe			
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0 20 = 3	<u> </u>		1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		ery, crematory o wn Mem. G	_	05/06/	2005	Т.	aVale. M	o rul ond
Baltim permit. Pag Department Important:		H	21. Signature of Funeral Service License		nescia			The second second	lams Famil			
Balt permit. Departi Import	Buc a		1466	1///	1				Cumberland	•		•
4		$\forall$	23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the	death. Do	not enter the m	node of dying, s	such as cardiac	or respiratory ari	rest,		Approximate Interval Between
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/Medi	_		disease or condition resulting in death)	Due to (or as a co	onsequence	e of):	1141	tot lock t	-			(D) 10.113.
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N. G.A.		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence	of):						
Box 68760, eath certificate be executed attending physician and	trans	Examiner	that initiated events	»								
760, b be exe sician a	ie i		resulting in death) Last	Due to (or as a co	onsequence	9 Of):						
876 Sate b	g eui	dical		d								
x 68 ertification	98	Me	IF FEMALE:	3c. If yes, outcome of p	regnancy					2	3d. Date of del	iven.
Box auth cert	Tor us	jan	in the past 12 months?	1 Live birth 2 □ 4 Pregnant at tim	Fetal deat	th 3 Ectopic 5 Other	pregnancy (specify)			2.	Month	Day Year
the de	Deu	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	o or obatir	3 💆 0 (110)	(Specify)					
Records, P.O. Box 68 The law requires that the death certifica the has been signed by the attending ph	deta	by Physician/Med	Part II. Other significant conditions con	ntributing to death but n	ot resulting	in the underlyin	g cause given i	in Part 1.	23e. Did to	bacco us	e contribute to	the cause of death?
Records, he law requires to has been signed									1 □ Y	′es 2□	]No 3□Pr	obably 4 Unknown
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Vital F vician: Th certificate	or. p	Be C	25. Was case referred to medical	<del></del>			20	6. Place of Dea	th (Check only or		1 1 103	20110
VISION Of VITA  Attending Physician: or death. ector: After this certifica	direct	To B	evaminer?	lospital: 1 Inpatient	2   ER/C	Outpatient 3	DOA Other:	4 Nursing H	ome 5 Resid	dence 6	Other (Spe	cify)
o Physical Control of Physical	eral	n:	27. Manner of Death	28a. Date of Injury (Month, Day Y	9ar) 28b	. Time of Injury	28c. Injury at Work?		28d. Describe h	now injury	occurred	
Division of lor Attending Phy after death. Director: After this	9 (2	Certification:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation			, , м	1 Tyes	s 2 No				
VIS r Atte er de recto	ph #	tific	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (		farm, street, fac	tory, office		28f. Location (S City or Tow	Street and vn. State)	Number or Ri	ural Route Number,
Div ital or A	i pel											
Divide Hospital or within 24 hours after To the Funeral Dir	completely filled in by the funeral director, page	ical	(Check only 2 Medical Exami	sician: To the best of ner: On the basis of ex	amination a	ge, death occurr and/or investigat	red at the time, tion, in my opini	date and place ion, death occu	, and due to the or rred at the time, or	cause(s) a date and	and manner as place, and due	s stated. e to the cause(s)
To the within 2	mplet	Medical	one)  29b. Signature and title of certifier	and manner stated	1.		29c. License n	umber		29d. Date	signed (Mont	h, Dey, Year)
T vit	3		230. Signature and title of certifier	00 .	1/1001	e	Des	600		Ma	111	1772
			30. Name and address of person who co	xen n	h (Itam 33-	(Type Print)	KUSS	000		1141	20	1000
			Manual Eller	alloule	6/1/	) 1/	Wolfe	SI	Bellin	neis.	MARUL	11/2/2001
To the second	Sta	te	31. Date filed (Month Pay, Year)	32. registrar's	Signature	A	V .		100 17 11 11	VAL.	1	
Re	aistr	_	WAL O D 20	US James	ها ديد اده	percue						

	•	1 - For State Registrar	State of Ma	arylan		artment of F	lealth and M Death		giene leg. No. 200	15 17116
Physicia	an	Decedent's Name (First, Middle, I	•	11.		7.11		2. Date of Dea Month		3. Time of Death
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Examin	er	The Tohas	Unabour .	Hace	1401	hai	Liner	7	N/	A
Funeral Director		5. Social Security Number 6 N/A	70 / K / I / I / I / I / I / I / I / I / I	e (In grs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min. 0 04	8. Date of Birth (Month, Day 05/04/20	, Year)	Birthplece (State or Foreign Country) aryland
pur .		Usuel Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	ecation				10d. Inside City Limits
Marylan f show	or	WV Miner	al			idgeley				1 ☐ Yes 2 ☐ No
r 28s-	Director	10e. Street and Number		1		10f. Zip Code			10g. Citizen of Wha	at Country?
th witi	ai D	Route 1 Box	: 105			2675			USA	
72 hours after death with the Maryla 72 hours after death with the Maryla 7 heturel: or Items 23a or 28s-1 shot 7 hours Exercities in that be rivillised at	by Funerai	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1	If Yes, specify Cuban, Mexican, Puerto F				ecify Yes or No- Rican, etc.)	American Indian, White, etc. White	
72 hc	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5	5+)	16a. Dece (Give life.		ation during most of work d)	ing	16b. Kind of Busin	ness/Industry
Hygies the talk		0 17. Father's Name (First, Middle, La	() ()			Infant	18. Mother's Name	e (First, Middle,	None Maiden Sumame)	2
uld be Mental Irked o	To Be	Israel	Shannon		Sibl	ey	Angela		ichelle	Carder
d 2 sho th and the mod 7 is me treuma		19a. Informant's Name/Relationship Israel S. Sibley /					and Number or Aur Ridgeley,			ite, Zip Code)
permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than eny injury or other treumatic event, ILLE MERGE.		20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spe	☐Removal from State	- 1	lace of Dispo emetery, crei	esition (Name of matory or other place)	ce)	Date 5/2005	20c. Location - Cit	
permit. P Departme importer eny injur		21. Signature of Funeral Service Lic		_//		2. Name and Addre	ss of Facility Ada	uns Family	Funeral Ho	ome, P.A.
Physician ate be executed Amedical Examiner Approximately transit	Ical Examiner	23a. rart1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Extrem Due to (or as  c. Due to (or as  d.	e pre a consequ a consequ	ence of):  uence of):  uence of):		ng, such as cardiac	or respiratory and	rest.	Approximate Interval Between Onset and Death
ding Physicien: The law requires that the death certificate be executed in Physicien: The law requires that the death certificate be executed h. After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1								of delivery Day Year
quires that (	by	Part II. Other significant condition	s contributing to death b	out not resu	ulting in the u	nderlying cause giv	ren in Part I.			ite to the cause of death?  Probably 4 Unknown
The law recate has bee	Completed								sy prio med? dea	re autopsy findings available in to completion of cause of th? Yes 2 \sumbed No
VILCION: icion: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Ott	26. Place of Deat			
ding Phys	tion: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investiga	28a. Date of Inju (Month, Da	ıry	ER/Outpatier 28b. Time o Injury	f 28c. Inju	4   Nursing Ho		ence 6 Other ( ow injury occurred	(Specify)
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific; completely illied in by the tuneral director,	Certification:	2 Accident Investiga 3 Surcide 6 Could no 4 Homicide determin	t be 29a Place of In	jury - At ho c. (Specif)	ome, farm, st	reet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
e Hospits 24 hours e Funerel etely filled	edical C		Physician: To the best teminer: On the basis of and manner st	f examina						
To the within To the	Me	29b. Signature and title of certifier	n N		0	29c. Licens	e number	-	29d. Date signed (A	Month, Day, Year)
		> May El	lon Kav	on	N H	D RES	-000	/	MAY 5,	2005
		30. Name and address of person w	AVOITE L	DO L	(Type,	IFE St.	BAHin	IRRE MA	ney land	21287
Sta Registi		31. Date filed (Month, Day, Year) MAY 0 6	32 Aegisti	rar's Signa	imie	all!			//	

			1 - For Stata Registrar	State of Maryla	-	ertificate of I			giene Reg. N2 0 0 5	17147
	Physici	an	Decedent's Name (First, Middle, Lass     Shannon	t) Kenneth	S÷	bley		2. Date of De.	Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give				Location of Deat	h	4c. County of De	ath
	Examili	lei	The Johns Hor	Kins Hospi	fal	DAH	MART		N/2	4
	Funeral		5. Social Security Number 6. Sol. N/A		s. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min. 0 03	8. Date of Birt (Month, Da 5/4/2005	th y, Year) 9. B	irthplace (State or Foreign
	Director		Usual Residence of Decedent				0 03	3/4/2003	) nar	yland
	yland		10a. State 10b. County	10c. 0	City, Town or I	ocation				10d. Inside City Limits
	e Ma	ctor	WV Miner	al al	Ri	.dgeley				1 ☐ Yes 2 No
	3e or 26	al Director	10e. Street and Number Route 1 Box 10	5		10f. Zip Code 26753			10g. Citizen of What 0	Country?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28e-f show other treumatic event, If a Medical Ever, if at must be inclifted at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 🌣 No If Yes, Give Year or Dates:	U.S. 13	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 21 No	ispanic Origin? (S in, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	- 14. Race - An Black, Wh Specify:	
Q 2	72 ho	ted	15. Decedent's Ed (Specify only highest gra		16a. Dec	edent's Usual Occup e kind of work done	ation	rking	16b. Kind of Busines	s/Industry
21215-0036	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired Infant	i)	, and	None	
5	e filed v Il Hygie other t vent, th		17. Father's Name (First, Middle, Last)			Illant	18. Mother's Nar	ne (First, Middle,	Maiden Sumame)	
Maryland	2 should be and Mental is marked o	To Be	Israel	Shannon		Sibley	Angela	Mic	chelle	Carder
	1 and 2 shoul Health and Mi em 27 is marl		19a. Informant's Name/Relationship (7 Israel S. Sibley /	,, ,		ling Address (Street and 2015).			er, City or Town, State, 33	Zip Code)
Baltimore,	ages 1 a nt of Hear : If Item or othe		20a. Method of Disposition 1 🏻 Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cr	osition (Name of ematory or other place		Date Oct / 2005	20c. Location - City of	
Εij	permit. Pages Department of H Importent: If Ite eny injury or of		' 4 □ Donation 5 □ Other (Specify  21. Signature 1 □ neral Service Licen			Mem. Garden:		06/2005	LaVale, Ma Funeral Hom	
Ba	Departiment Department		VKIL C	Dolum!	1				id, MD 21502	e, 1 .A.
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	an. Do not e	nter the mode of dyin	1 1	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):		/			
8760,	certificate be executed nding physician and use as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury that initiated events resulting in death) Last							
9	ertificati ding phy e as the	Medic	IF FEMALE:	23c. If yes, outcome of preg						
O. Box	death e atter	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of d Month	elivery Day Year
rds, P.	es De pe	leted by PI	Part II. Other significant conditions o	ontributing to death but not re	esulting in the	underlying cause giv	en in Part I.	23e. Did to	obacco use contribute Yes 2 No 3 F	to the cause of death?  Probably 4 Unknown
Vital Records,	The ate his page	Complet								
/ita	Physicien: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?					ath (Check only o	ne)	
of	Physic this c	ို	1 Yes 2 No		ER/Outpatio		4   Nursing r		dence 6 Other (Sp	ecify)
ion	Jing After fune	atlon	27. Manner of Death  1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Worl	yat k? Yes 2 □ No	28d. Describe i	now injury occurred	
Division	or At fler d Sirect in by	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, s	treet, factory, office		28f. Location (5 City or Tox	Street and Number or I vn, State)	Rural Route Number,
	Hospite 24 hours Funeral tely filled	edical C		ysician: To the best of my k niner: On the basis of examinand manner stated.						
	To the within 2 To the comple	Med	29b. Signature and title of certifier	A Committee of the Comm	-	29c. Licens	e number		29d. Date signed (Mor	nth, Dey, Year)
)	->-0		► (1/ Jun 400	en Kunou	e Mi	D RAS	-000		Mail 5	2005
			30. Name and address of person who	completed cause of death (It	1	p, Print)	1.16-5	L Mall	1119 D)	2005 Have 2127
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	Darle	ICITE D	1 - NAH,	140KG 111AK	YIAM XIdi
	Regist	rar	MAY 0 6 2	005	10. V	gover				

Amended #4c, nls, 05/05/05, Allegany County Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 1 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 05-02-05 Day Year **Physician** 9:00 рм Duane Frances Shaffer /Medical 4c. County of Death
-Allegheny ALLEGANY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frostburg, MD. St. Vincent DePaul If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 8-11-1925 **Funeral** 9. Birthplace (State or Foreign Country)

MD **X**M 2□ F Months Days Hours Yrs. 79 Director 220 16 6337 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits or 28a-f show treumatic event, the Medical Examinar must be notified at MD Allegany Ellerslie 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14514 Ellerslie Road 21529 USA Items 23e Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status MOYes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 43-146 1 ☐ Yes XXNo Specify: White þ Specity: 3 Widowed 4 Divorced Year or Dates: "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Gas utility delivery Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Kenneth L. Shaffer Myna (mnu) Albright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: It item 27 is eny injury or other treu once. Karen L. Golden, daughter 715 Nemacolin Avenue, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 Creptation 3 □ Removal from State

1 Denation 15 □ Other (Specify) Restlawn Memorial Pk : 5-6-2005 Lavale, MD 21. Signature of Fineral Service Signature 22. Name and Address of Facility Harvey H. Zeigler Funeral Home, Hyndman, PA bations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, be cause on each line. 23a. Part L. Enter the disease, or complishock, or heart failure. List only or Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic 6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine physician and the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★Unknown Completed Dee.n 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an cate has by page 2 s 2**/** No certificate 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 🛣 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending death. investigation Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

E Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 03, 2005 worseches DO055325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 48 Tarn Terrace Frostbury mill WONSOCK SMIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 4 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Daniel Alfred Schadt 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner (TENERAL JORCHESTER DGE If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min 1 M 2 □ F Yrs. Director 205-30-8525 1936 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits other treumatic event, the Michigal Examinatings be notified at 1 XYes 2 □ No Director MD Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 Noble Street 21643 Items 23e USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ō 1 ☐ Yes 2 X No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Korea 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) agriculture 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be be n and Mental I Thomas E. Schadt Esther Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 is any injury or other tre once. Barbara Schadt wife 300 Noble St., Hurlock, MD 21643 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Reich Cemetery 5/13/05 Marietta, PA 21. Signat Funeral Septice Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. fmmediate Cause (Final disease or condition resulting in death) Chronic **Physician** OBSTRUCTIVE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death.
Funerel Director: A investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

Dram ble

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100

32. Registar's Signature

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

MAY 2 0 2005

			State of Maryland / Department of Health and M		•	
			1 - State Registrar Certificate of Death		g. No. 005	17151
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Deat May 5, 2	h Ray Year	3. Time of Death
	/Medic	al		may 5, 2	T	4:05Р.М. м
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Charles County Nursing & Rehab. Center LaPlata		4c. County of Dea	tn
Ī	Funeral Director			8. Date of Birth (Month, Day, Dec. 11;	9. Bin C Ma	thplace (State or Foreign ountry) ry Land
	/land low et		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e Man le-fsh lifted	ctor	Md Charles LaPlata			1X Yes 2 No
	with th	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What C	ountry?
	ns 23	Funeral	10200 LaPlata Road 20646  11. Marital Status   12. Was Decedent Ever in U.S. Armed Forces?   13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	U.S.A.	erican Indian,
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or Items 23a or 28e-1 show eumatic event, the Medical Event are must be notified at	by	Armed Forces?  1 X Never Married 2 Married  1 Yes, 2 X No  1 Yes, Give  1 Yes, Give  1 Yes 2 X No  1 Yes 2 X No  1 Yes 2 X No  1 Yes 2 X No  1 Yes 2 X No  1 Yes 2 X No  1 Yes 2 X No	Rican, etc.)	Specify: Wh	
2-0	72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	ing	16b. Kind of Business	
12	within ene. then '	Jumo	Elementary/Secondary (0-12) College (1-4or 5+)    Website DO NOT use retired		Thrift St	ore
<u>5</u>	Hygi other	Be Co	17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle, M		
ylar	should be filed vind Mental Hygies marked other tumatic event, III	To B	Josiah H. Tice Lottie C	Chaney		
, Maryland 21215-0036	s 1 and 2 should f Health and Mer item 27 Is marke other treumatic		19a. Informant's Name/Relationship (Type, Print)  Herbert G. Tice, Sr / Brother  19b. Mailing Address (Street and Number or Runt)  10c. Box 325 Mechanicsvi			Zip Code) 0659
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If item 27 It eny injury or other tre		20a. Method of Disposition 1  Burial 2  Cremation 3  Removal from State 1  Donation 5  Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Brinsfield-Echols Crem 5-7-	Cl	20c.Location-City or narlotte H	
Balti	permit. Departm Importa eny inju		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Brinsfield-Echols F	2.50	Home,,P.A.	17 1/1 00/00
F			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arre	est,	Approximate Interval Between
E	Pnysician :		Immediate Cause (Final disease or condition			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):			
	outed id ansit	Examiner	that initiated events			4
,097	te be executed ysician and ie burial-transit	I Ex	resulting in death) Last Due to (or as a consequence of):			
6876		dical	d			
Box 6	leath certificate attending phy I for use as the	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of de	livery
	death ne atte ed for	slcia	in the past 12 months?  1  Yes 2 XNo  4 Pregnant at time of death 5 Other (specify)		Month	Day Year
P. O.	nat the de d by the a letached	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	22a Did tob	acco use contribute to	the cause of death?
Records,	The law requires that the death certifica tie has been signed by the attending phoage 2 should be detached for use as the	by	Parti. Other significant conditions continuing to death but not resulting in the underlying cause given in Parti.	1 🗆 Ye	37	robably 4 Unknown
	The taw rate has be page 2 sh	Completed		24a. Was an autops perform	24b. Were a prior to death?	utopsy findings available completion of cause of XXNo
Vita		BeC	25. Was case referred to medical examiner?			
	Phys this al dii	<sup>L</sup> O	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: XX Nursing Ho		nce 6 Other (Spe	cify)
O	ding Ith. After funer	tlon	1 Natural 5 Pending (Month, Day Year) Injury Work?	28d. Describe no	w injury occurred	
Division of	i Diri	Certification;	2 Could not be	28f. Location (St. City or Town	reet and Number or R , State)	ural Route Number,
	Hospite 4 hours Funeral ely filled	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and the control of the date and the control of the date and the control of the date and the control of the date and the control of the date and the control of the date and the control of the date and the control of the date and the control of the date and the control of the date and the control of the date and the control of the date and the control of the date and the control of the date and the control of the date and the control of the date and the control of the date and the control of the date and the date and the control of the date and the control of the date and the control of the date and the control of the date and th	and due to the ca red at the time, da	use(s) and manner a ite and place, and du	s stated. a to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier 29c. License number	25	d. Date signed (Mon	h. Day, Year)
			D52289	Ma	y 6, 2005	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
	Sta	to	Nalin Mathur, M.D. 10 St. Patrick's Drive Suite 404 Wa 31. Date filed (Month, Day, Year)  32. Register's Signature	ldorf, M	aryland 2	20603
	Registr		MAY 1 0 2005 Liven & freek			

	1	For State Registrar	State of Maryland /	Department of Health and Certificate of Death		giene 109. No. 2005 1716
Physicia /Medica Examine	in al er	1. Decedent's Name (First, Middle, Last)  Margare  1a. Facility Name (If not institution, give s	t Thom	4b. City, Town, or Location of D	2. Date of Dea Month	
Funeral Director		5. Social Security Number 6. Sex	*	birthday) If Under 1 Year If Under 24 I	Hrs. 8. Date of Birth (Month, Day MAR . 16	(Year) 9. Birthplace (State or Fore Country) MD
filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or tiems 23a or 28e-f show ont, the Medical Evaminar must be notified at	-	MD QUEEN AN		own or Location		10d. Inside City Liπ 1 ☐ Yes 2 🌠
ath with ir	rai Dire	1356 CALVERT ROAD		10f. Zip Code 21619		10g. Citizen of What Country?  USA
Billied with 72 nouts after deain with the Marylan hall Hygiene than "naturel", or flems 23a or 28e-f show or other than "naturel", or flems 23a or 28e-f show event, the Medical Evantinat must be notified at	by Fur	11. Marital Status 1 □ Never Married 2 □ Married 3 翼 Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Croces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pi 1 ☐ Yes 2 ▼ No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: WHITE
ne. han "natu e Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	5a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working	16b. Kind of Business/Industry
a E o o	To Be Cor	12 17. Father's Name (First, Middle, Last) PERCY A. STALLING:	S	MARY	Name (First, Middle, HOXTER	
6 2 3		19a. Informant's Name/Relationship (Ty. CLIFFORD THOMPSON)		9b. Mailing Address (Street and Number of 1824 ST. MARY SRD.,		
ent of Health nt: if item 27 ry or other tr		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	20b. Place ceme	of Disposition (Name of tery, crematory or other place)  INSVILLE CEMETERY 05	Date	20c. Location - City or Town, State  STEVENSVILLE, MD
Department of H Importent: If ite any injury or ot once.		21. Signature of Funeral Service Ligense			EIN & NEWN	AM FUNERAL HOME, P.A
ysicia	cal Ex	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	ce of):	neck	Interval Between Onset and Death
ad by the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown			23d. Date of delivery  Month Day Year
n signed by		Part II. Other significant conditions cor	-	g in the underlying cause given in Part I.	23e. Did to	bacco use contribute to the cause of death es 2000 3 Probably 4 Unkno
	Completed by				24a. Was a autops perform	sy prior to completion of cause
this cer	o B L	25. Was case referred to medical examiner?  1   Yes   2   No   F	1	Other		nence 6 □Other (Specify)  by injury occurred
after dea	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Si City or Town	treet and Number or Rural Route Number, n, State)
5 6 6			picien: To the hest of my knowled	dge, death occurred at the time, date and pl	ace, and due to the c	ause(s) and manner as stated.
	Medical	29a. Certifier (Check only one)  2 Medicel Examin	ner: On the basis of examination and manner stated.	and/or investigation, in my opinion, death o	ccurred at the time, d	ate and place, and due to the cause(s)

	Paul Mc 05-0296	nr 8	oe Trigger Pleas	e Type or Pr	int in Bla	ack Ind	elible Ink	. Ensure A	II Copies	Are	Legible.		
Amende	crn ed,31,14		F.D., <b>1-</b> State Registrar TCHD, 05/0		/laryland		rtment of H	Health and M <i>Death</i>	•	giene Reg. No.	nn5	1715	3
			Decedent's Name (First, Middle,	Last)					2. Date of De	ath		3. Time of Dea	ith
	Physici /Medio		Paul Monr	oe Trigge	r				April	Day 29		1:45 I	$P^{M}$
	Examir		4a. Facility Name (If not institution,	give street and numbe	r)		•	or Location of Death			County of Deat		
			Dorchester Gene					ridge			Dorches		
	Funeral Director			5. Sex 7. A 1 M M 2 □ F	Age (In yrs. las	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)		nplace (State or For untry)	reign
			Usual Residence of Decedent		45				Dec.6,	1959	Mar	yland	
	yland how		10a. State 10b. County		10c. City,	Town or Loc	ation					10d. Inside City Lin	
	the Marylar 28a-f chow	ctor	Maryland Dorche	ster	Cam	bridge						1 ☐ Yes 2 ☐	]No
	with th	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Co	untry?	
	e 23a	erai	405 Henry	Street 12. Was Deceder	t Ever in II C	12 \4	21613		acifu Vac as No		USA 14. Race - Ame	rican Indian	
	fer dea	Fun	11. Marital Status 1 □ Never Married 2 □ Married	Armed Forces	s?	ls. W	Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		Black, White	e, etc.	
036	ours after death with the Maryla rat', or Itame 23a or 28a-f ehov Exarciner cust be multiled at	by	3 ☐ Widowed 4 🌠 Divorced	If Yes, Give Year or Dates	•	1	∐Yes 2. No	Specify:			Specify: WHI	TE lack	
5-0	72 hours natural',	eted	15. Decedent's (Specify only highest			16a. Decede	int's Usual Occup	pation during most of work	ina	16b. Kir	nd of Business/l	ndustry	
21215-0036	vithin ne. han	Completed by Funeral	Elementary/Secondary (0-12)	College (1-4o	r 5+)			during most of work d)					
7) q	filed within 72 hours after death with the Maryland Hygiene. thar than "natural", or Itame 23a or 28a-f ehow ant, the Modical Examiner must be molified at	ပိ	10 17. Father's Name (First, Middle, La	ast)		_Sanit	ation W	orker 18. Mother's Name	e (First, Middle,			prises,In	IC.
au	ld be ental kad o	To Be	Paul A. Trigger					Juanita			-2		
Maryland	shou and M s mar	-	19a. Informant's Name/Relationship			19b. Mailing	Address (Street	and Number or Run			Town, State, Z	ip Code)	
	and 2 saith a n 27 is		RenaDill /Fia	ncee		405 He	nry Str	eet, Camb	ridge,M	ary1a	and 216	13	
Baltimore,	of He of He If itan or oth	-	20a Method of Disposition 1 ☐ Boxial 2 ② Cremation 3	Removal from Stat	0.00	e of Dispos netery, crem	tion (Name of atory or other pla	сө)	Date	20c. Loc	cation - City or	Town, State	
Ë	Pag tment tant:		'4 □ Donation 5 □ Other (Spe	ocify)	Сар	- T	remator		-2005	Dove	r,Delaw	are	
Bal	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene Important: If itam 27 is markad othar than "natur any injury or other traumatic evant, the Modical	1	21. Signature of Funeral Service Lie	censel L		— Ве	Name and Addre	ith Funer	al Home				
			23a. Part 1. Enter the disease, or co	on flications that cause	ed the death.			Street, Canal Such as cardiac			ryland	21613 Approximate	
	Dhusisian		23a. Part1. Enter the disease or of shock, or heart failure. List or Immediate Cause (Final	nty one cause on each			+ NOU		,	,		Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	aDue to (or a	a consequer		TNOU	1445					-
	Examiner		Conventially lies and distance	h	82	,							
	p #	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a consequer	nce of):							
	executed and al-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or a	is a consequer	and of):							
,09					is a consequen	100 01).							
687	tificate being physicial as the buri	edic		d									
×	eath certi	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom						2	3d. Date of deli	very	
P.O. Box 68760	Physician: The law requires that the death certificate be this certificate has been signed by the attending physiciaral director, page 2 should be detached for use as the bur	by Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No		2 Fetal de at time of deat		ctopic pregnancy Other (specify) _	y 			Month	Day Year	
P.O	at the d by the	Phys	9 Unknown										
	signed d be del		Part II. Other significant condition	s contributing to death	but not resulti	ng in the un	lerlying cause giv	en in Part I.	239. Did to			the cause of death?	
0.00	w requir	etec							-				
Rec	The lay ate has page 2 :	Completed									prior to c death?	opsy findings availa ompletion of cause	of
ta	ician: Th certificate ector, pag	0	25. Was case referred to medical		<u> </u>			26. Place of Death		2 No	1V Yes	2 □ No	
<u> </u>	ysician: is certific director,	0 B	examiner? 1∑Yes 2□No	Hospital: 1 □ Inpa	tient 🎾 EF	VOutpatient	3□ DOA Oth				Other (Spec	ify)	-
0	ding Ph h. After th funeral	Ju: T	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of In	jury 28 Day Year)	Bb. Time of Injury	28c. Injur Wor		28d. Describe h			1000	
Sio	ttandii death. stor: A	catio	2 Accident investigat 3 Suicide 6 Could no	11 11	2005 1	3:00	M 1 🗆	Yes 2 No	resiet.	shet	by po	ile	
Division of Vital Records,	or Attanding ifter death. Diractor: After in by the fune	Certification:	4 Homicide determini	ed 28e. Place of li building,	njury - At homi etc. <i>(Specify)</i>	e, farm, stre How	at, factory, office		28f. Location (S City or Tow 465 If EG	un Statol	e . / (2)	ral Route Number,	
u	spital ours a naral (		29a. Certifier 1 ☐ Certifying	Physician: To the bes	st of my knowle	L				7	Colour	stated MI	/
	To the Hospital or Attandi within 24 hours after death. To the Funaral Diractor: A completely filled in by the fi	edical	(Check only 27 Medical Ex	taminer: On the basis and manner	of examination	n and/or inve	stigation, in my o	ppinion, death occurr	ed at the time,	date and	place, and due	to the cause(s)	
	To th Withir To th comp	Me	29b. Signature and title of certifier		10		29c. Licens	se number		29d. Date	signed (Month	, Day, Year)	
			· Caline	Mah 1	45		0	.C.M.E.		Apri:	1 30, 20	005	
	(2)		30. Name and address of person wh	no completed cause of	death (Item 2)			ook D-1.	4	M-	1 - 1 04	201	
	1		ZABILLU  31. Date filed (Month, Day Year)		trar's Signatur		enn Str	eet, Balt	ımore,	mary.	Land 21	ZUI	
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 0 5 2	005	, ar 3 Signatur	1	20 H	AY 0 4 200	5		MA		

State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 13, Year **Physician** 2005 9:55 PM M Virgilio Albert /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5415 Jefferson Blvd. Frederick 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nov. | 6, 1913 5. Social Security Number 9. Birthplace (State or Foreign Country) New York **Funeral** 1 M 2 □ F 124-07-4466 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 27 No Frederick Director Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21703 5415 Jefferson Blvd. U.S.A. or Items 23e Funera 12. Was Decedent Ever in U.S. Armed Forces?

1 Control of the process of the pro Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College,(1-4or 5+) Elementary/Secondary (0-12) Manafacturer Ladies Garments 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ferdnand Virgilio Bernadette Faranacci 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m any injury or other treum once. Noreen Wright/Daughter 5414 Jefferson Blvd., Frederick, Maryland 21703 20b. Place of Disposition (Name of cemetary, crematory or other place)
Smithsburg Crematory May 16, 2005 Smithsburg Maryland 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 21. Signiture of Funeral Service License Reeney and Basford PA\_Funeral Home M00021 Killara 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications to at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 5 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a nonsequence of) Examine executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. certificate be Physiclan/Medical IF FEMALE: 23c. if yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) P.O. F 9 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ ANTHRI 1 Yes 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ Ho} \) 24a. Was an certificate 1 ☐ Yes 2 NO Physicien: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Assidence 6 Other (Specify) 2 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: Injury at Work? To the Hospitel or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Cetifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 9 D-31912 May 16, 2005 MD 2002 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) oposium roux Plus theDERICH mp MELOCAL mi) - 1564 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 2 0 2005 Registrar

				ype or Print in Bla				-		.egible.	
			_ ror	State of Maryland /				lental Hyg	iene	005	17155
			1 - State Registrar		Cer	tificate of l	Death		eg. No.	000	1/100
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  CHARLES	LESLIE		WALTE	R SR.	2. Date of Dea Month MAY 14	Day	2005	3. Time of Death
	Examin		4a. Facility Name (If not institution, give s VA MARYLAND HEALTH			4b. City, Town, or	PERRY PC	TNT	4c. C	CECII	
	Euparal		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs.	8 Date of Birth	1		place (State or Foreign
ı	Funeral Director			<sup>M 2□F</sup> 82	Yrs.	Months Days	Hours Min.	2/15/	1923	Ma Ma	aryland
	should be filed within 72 hours after death with the Maryland and Mently Hygiene. Ind Mentla Hygiene. Inakted other than "natural", or itema 23a or 28a-f show makted other than "natural", or itema 23a or 28a-f show umatic event, it a Modical Examinar must be notified at	or	10a. State 10b. County MD. Baltim	10c. City, To	own or Loc		Baltimo:	re			10d. Inside City Limits 1 ☐ Yes 2 ♠No
	the N	ect	10e. Street and Number	016		10f. Zip Code	Dar ormo.		l0g. Citiz	en of What Cou	ntry?
	3a or	0	6225 York Ro	ad			21212		Ur	nited S	States
	death	Funeral Director		Was Decedent Ever in U.S.     Armed Forces?	13. V	Vas Decedent of H	ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No-		4. Race - Ameri Black, White,	can Indian,
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiens. Department of Health and Mantal Hygiens. Insture!, or Itema 23a or 28a-f show mortal it flom 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Madical Examinal must be ruillfast at once.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 M Yes 2 □ No If Yes, Give WW II Year or Dates:		☐ Yes 2 No	Specify:	, , , , , , , , , , , , , , , , , , , ,	3	Specify:	nite
5	'2 hou	ted	15. Decedent's Educ		6a. Deced	ent's Usual Occup	ation during most of work	ring	16b. Kin	d of Business/In	
171	within 7 ene. than "r	Completed	(Specify only highest grade	College (1-4or 5+)	life. C	NOT use retired	1)		Home	e Impro	ovement
7 2	filled Hygi other ent, I		17. Father's Name (First, Middle, Last)	0		11001	18. Mother's Nam				
2	uld be fental rked (	To Be	Edward	Wal	ter		Thel	ma			Kurts
Mary	2 shou and N is ma		19a. Informant's Name/Relationship (Typ								<sup>Code)</sup> 21084
Σ 	and and and m 27 m 27 rer tr		Charles L. Walt								Maryland
5	Pages 1 nent of H int: If itel iry or oth		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Re	emoval from State	etery, crem	sition (Name of natory or other place	(e)	Date		ation - City or To	
allillion	it. Pa rtmen rtant: njury		' 4 □ Donation 5 □ Other (Specify)	darro		Cremati Name and Addre					Maryland
ם ם	permit. Departr Imports any inju		21. Signature of Funeral Service License	on Kuch II	1)		U				aryland
			23a. Part1. Enter the disease, or complic	cations that caused the death. [			rtz & S			. поше	Approximate
	Dhysisian		shock, or heart failure. List only on Immediate Cause (Final		10 % C/III	TMDDOMTO	.AT				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequent		INFECTIO	'IN				UNKNOWN
	Examiner		Sequentially list conditions								
-	P ##	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter the arriving Cause (Disease or injury that satisfied execution)	Due to (or as a consequent	ce of):						
	be executed sician and burial-transit	Examiner	that initiated events cresulting in death) Last	.  Due to (or as a consequent	ce of):					-	
Š	be ey iician buria	a									
00	certificate nding phys use as the	edic	0							T	
ŏ	anding use a	N/M	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal de		Ectopic pregnancy	,		2:	3d. Date of deliv	*
מ	that the death certificate ed by the attending physi detached for use as the	Physician/Medic	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death		Other (specify)				Month	Day Year
ŗ.	requires that the een signed by th nould be detache	/ Ph	Part II. Other significant conditions con	tributing to death but not resulting	ng in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco us	e contribute to t	he cause of death?
S	w requires that been signed k should be deta	d by	CHRONIC RENAL FAIL	JURE, CORONARY	ARTEF	RY BYPASS	,	1 🗆 Y	es 2	No 3□Prol	bably <b>X</b> _Unknown
Hecords		Completed	HYPERTENSION					24a. Was a		24b. Were auto	opsy findings available
	The la	E O						autop: perfor 1 Yes	med? 2 No	death?	ompletion of cause of 2□ No
Vital		Be C	25. Was case referred to medical examiner?				26. Place of Deal	th (Check only or	ne)		
0	Physician: this certific al director,	To	1 Yes 2 XNo	ospital: 1 ☐ Inpatient 2 ☐ ER			er: 4 Nursing H				fy)
	D 0 0	lon:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	lb. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe h	ow injury	occurred	
Sion	Ta a	lcat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home	a farm stre		143 2 140	28f. Location (S	treet and	Number or Run	al Route Number,
	after Direct	Certification;	4 Homicide determined	building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	oot, radiory, office		City or Tow			
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director, Att completely filled in by the fur		29a. Certifier 1 Certifying Phys	sician: To the best of my knowle ner: On the basis of examination	dge, death	n occurred at the tir	ne, date and place,	and due to the o	ause(s) a	and manner as s	stated.
	the hin 24 the F	Medical	one)	and manner stated.		29c. Licens				signed (Month,	
	or or	~	29b. Signature and title of certifier			250. Liberts					_
			30 Name and address of account to	molecular cause of death (from 0'	Sa) (Tuno	Print)	D19402		MAY	14, 200	
	110		30. Name and address of person who co	1			CARE SYSTI	EM, PERR	Y PO	INT, MD	21902
	Sta	ate	31. Date filed (Month) Day. Year 2005	32. Registrar's Signature							
	Regist	iar	MATE DE LOUS	parties of the same	A. C. C. C. C. C. C. C. C. C. C. C. C. C.						

	Ψ		1 - For State Registrar	State of Maryl		artment of F			giene ()	05	17156
i	Physici /Medic		1. Decedent's Name (First, Middle, Last) Frank Lloyd Weaven	, III				2. Date of De Month May	Day	Year 05	3. Time of Death $10:00P^{M}$
	Examin		4a. Facility Name (If not institution, give s Cherry Lane Nursin			4b. City, Town, o		Death		ty of Death	
	Funeral Director		5. Social Security Number 6. Sex		yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Da	th v. Year)	9. Birth	place (State or Foreign intry)
	aryland show del	Į.	Usual Residence of Decedent  10a. State 10b. County		City, Town or Lo	ocation					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ith the Mi or 28a-f	Funeral Directo	Maryland   Prince Ge		College 1	10f. Zip Code			10g. Citizen of	What Cou	
	s 23s	eral	9314 Cherry Hill F	Road #108  12. Was Decedent Ever i	nIIS 12 1	2074		2 (Specify Ves or No	United	d Stai	
036	urs after d el', or Item sternir et	by	1 Never Married 2 Married 3 Widowed 4 Married	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	1	_	Specify:	? (Specify Yes or No Puerto Rican, etc.)	Bla Specia	ack, White,	
215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "naturel", or items 23a or 28a-f show event, the Modical Exemical mail to nailified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation o completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of d)	f working	16b. Kind of E	3usiness/In	idustry
2	filed withi Hygiene. other than ent, the M	Соп		3	Insu	cance Bro		A		Insura	ance
Maryland 21	od is b	To Be	17. Father's Name (First, Middle, Last) Frank Lloyd Weaver				Kathr	Name (First, Middle, yn Ingberg	5		
Mar	d 2 sh th and th and 7 is m treum		19a. Informant's Name/Relationship (Ty)  Kristine DeWitt /	Ť				or Rural Route Numbe			
Baltimore,	permit. Pages 1 and 2 should Depertment of Health and Mer Importent: If item 27 is marke any injury or other treumatic once.		20a. Method of Disposition  1 Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)	emoval from State	b. Place of Dispo cemetery, crei	sition (Name of natory or other place	(e) Ma	Westmins	20c. Location	- City or To	own, State
Baltir	permit. P Depertme Importen any injur.		21. Signature of Fuperal Service License		Re	Cremator 2. Name and Address thaven	ss of Facility Funeral	l Services	, Skkot	Cody	faryland
	Physician		23a. Pan. Ener the disease, ir combine shock, or heart failure. List only in Immediate Cause (Final	e cause on each line.	leath. Do not ent	er the mode of dyin		n. Hwy. Fr rdiac or respiratory a		:, MD	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Respirator Due to (or as a con	sequence of):		ar				
8760,	sate be executed obysician and the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying that initiated events resulting in death) Last  Metastatic Esophaseal Cancer  Due to (or as a consequence of):  C.  Due to (or as a consequence of):									
.O. Box 68	death certific e attending p id for use as	ysiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	3c. If yes, outcome of pre 1	etal death 3	Ectopic pregnancy Other (specify)	,		I	ate of delive	ery Day Year
<b>_</b>	ires that the signed by detaction	d by Physi	Parl II. Other significant conditions con Multiple Cerebrov			nderlying cause giv	en in Part I.	1 _	_		the cause of death?
Records,	nysician: The law requires that the its certificate has been signed by the director, page 2 should be detached.	Completed	-						rmed?	prior to co death?	opsy findings available ompletion of cause of
Vital	G C	Be C	25. Was case referred to medical examiner?				26. Place of	1 ☐ Yes  Death (Check only of	2⊠ No   ne)	1 🗆 Yes	2 No
o	<u>a</u> = <u>a</u>	၉	1  Yes 2 No P  27. Manner of Death 1 Natural 5 Pending	lospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatier 28b. Time of Injury	28c. Injur	y at k?	ng Home 5 Resid			fy)
Division	or Atten ifter deat Director; in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp			Yes 2 □ No			ber or Rura	al Route Number,
_	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical C	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my ner: On the basis of exan and manner stated.	knowledge, death	n occurred at the tin vestigation, in my o	ne, date and p pinion, death	place, and due to the occurred at the time,	cause(s) and m date and place,	anner as s , and due to	itated. o the cause(s)
	To the Ho within 24 I To the Fu completely	Me	29b. Signature and title of certifier		^	29c. Licens	e number		29d. Date signe	ed (Month,	Day, Year)
			· Wita K.	trak 1		D 202	.51		5/3/20	005	
		ļ,	30. Name and address of person who co Dr. Gita K. Shah	mpleted cause of death (7350 VanDus		•	-1. MD	20707			
	Sta	te	31. Date filed (Month, Day, Year)	100			LII e L	20/0/			
	Registr	ar	MAY 0 9 2	UUD	ignature	The state of					

William L. War

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Ma 7: 20 A M LEE WARD 2,2005 WILLIAM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** ALLEGANY LIONS MANOR NURSING HOME CUMBERLAND If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birth Day, Year)

9. Birthplace (State or Foreign Country)

10,1929 WEST VIRGINIA 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months **X** M 2 □ F 76 Director JAN. 219-22-232<u>5</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other treumetic event, It's Madical Examiner aust be notified at 1 ☐ Yes 2 XNo Director ALLEGANY CRESAPTOWN MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21502 U.S.A. or Items 23e 12914 6th. AVE., S.W. Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. ¶Yes 2☐ ¶Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes X ☐ No Specify: WHITE Specify: WWII 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. In: If Item 27 is marked other then "nry or other treumetic event. Elementary/Secondary (0-12) College (1-4or 5+) SHEET METAL WORKER SHEET METAL 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) GLACE HOLBERT CECIL WARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James 13702 FIRTREE LANE, CRESAPTOWN, MD 21502 JAMES H. LEASE / BROTHER-IN-LAW Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages ' 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any injury or once. SUNSET MEMORIAL PARK 05/14/2005 CUMBERLAND, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) Physician 15TASTATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence of: Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760,

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

4☐Pregnant at time of death

24a. Was an autopsy 1 Yes 2 No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes

Day

Year

25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No 27. Manner of Death

1 Natural
2 Accident

28a. Date of Injury (Month, Day Year) 5 Pending investigation

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

29b. Signature and title of cenific Ca

#D0054004

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year) May 16, 2005

30. Name and address of person whi completed cause of death (Item 23a) (Type, Print)

LaVale, MD 21502 MD Khanna 122 31. Date filed (Month, Day, Year) 32. Resistrar's Signature

State Registrar

the

detached

page 2 should

this

After

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Be Completed

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Certification;

Medical

29a. Certifier

(Check only one)

P.O.

Records,

Division of Vital

the Hospitel or Attending Physicien:

death. after death Director:

To the Hospinal within 24 hours after To the Funerel Dir

120

IF FEMALE:

23b. Was decedent pregnant

9 🗌 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

MAY 1

sician	1. L	Decedent's Name (First, Middle, Last	")			'	2. Date of Death Month	Day_ Year	3. Time of Death
edical		Shirley Willey					May 4, 2	2005	1,100
miner	4a.	Facility Name (If not institution, give			4b. City, Town, or Loca			4c. County of De	
ral	5.5	Dorchester Gene Social Security Number 6. Se		. last birthday)	Cambri		B. Date of Birth	Dorche	
r	2		M 20 F 72	Yrs.	Months Days Ho	urs Min.	June 7,		rthplace (State or Forei country) aryland
	10a	. State 10b. County		ity, Town or Lo					10d. Inside City Limi
Funeral Director	M	aryland Dorchest	ter		Cambridge				1 (1 yes 2 (1) N
Dire		o. Street and Number			10f. Zip Code		10g	g. Citizen of What C	
erai	-	03 Roslyn Avenue	12. Was Decedent Ever in U	IS 13 1	21613	ic Origin? /Spec	ify Yes or No-	14. Race - Arr	USA Jerican Indian
Fun		Marital Status  1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 ☐ Ho		Was Decedent of Hispani If Yes, specify Cuban, Me		ican, etc.)	Black, Wh	
þ		3 DWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ Mo Spe	ecify:		Specify:	White
Completed		15. Decedent's Edi (Specify only highest grad		(Give	dent's Usual Occupation kind of work done during	most of working	16	6b. Kind of Busines	s/Industry
mpie	E	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)		<b>^</b>	-1 -1 -	
S	17	10 Father's Name (First, Middle, Last)			Crab Picker	Jothor's Name	First, Middle, Ma	Shellf	ish
Be	17.	Charles Travers	3		10.1		nnie Mee		`\
5	19	a. Informant's Name/Relationship (T		19b Mailir	ng Address (Street and N				Zin Code)
		ianna C. Travers,			-				
	1	Method of Disposition	20b.	Place of Dispo	sition (Name of	Da		c. Location - City o	
		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hamovai trom State		matory`or other place) er Mem. Park	5/9/2	005	Cambridge	. MD
zi)		. Signature of Funeral Service Licens							, IID
once		Hours d-	Dranus	ell 3	Name and Address of F Curran-Bronnw 108 High St.	ell fun Cambr	eral Hom idge. MI	ne, P.A. 21613	
	23	a. Part1. Soter the disease, or comp shock, or heart failure. List only	lications that caused the dea						Approximate Interval Between
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		sulting in death)	Due to (or as a conse			-			N WECK
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45									
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Certification: To Be Completed by Physician/Medical	IF 23	Was case referred to medical examiner?  Unknown  Was case referred to medical examiner?  I Natural sinvestigation  Accident sincide determined  Check only one)  Les Cisease or injury to	Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  For a consect.  Due to (or as a consect.)  Hospital:  Due to (or as a consect.)  Property of the part of	quence of):  nancy al death 3 death 5	Other (specify)  26.   1 3 DOA  Other: 4  f 28c. Injury at Work?  1 Yes  reet, factory, office  cocurred at the time, da vestigation, in my opinion  29c. License num	Place of Death Nursing Hom 28 2 No 28 ate and place, ar death occurred	24a. Was an autopsy performe 1 Yes 2 Check only one) e 5 Residence id. Describe how if Location (Strecity or Town, and due to the caud at the time, date	Month  cco use contribute  2 No 3 F  24b. Were a prior to death? 1 Ye  ce 6 Other (Sp  injury occurred  et and Number or F  State)  se(s) and manner as a and place, and du	Day Year  to the cause of death?  Probably 4 □Unknow  Lutopsy findings available  completion of cause of  s 2 No  Probably 4 □Unknow  Lutopsy findings available  completion of cause of  s 2 No  Probably 4 □Unknow  Lutopsy findings available  completion of cause of  s 2 No  Probably 4 □Unknow  Lutopsy findings available  completion of cause of  s 2 No  Probably 4 □Unknow  Lutopsy findings available  completion of cause of  s 2 No  Probably 4 □Unknow  Lutopsy findings available  completion of cause of  s 2 No  Probably 4 □Unknow  Lutopsy findings available  completion of cause of  s 2 No  Probably 4 □Unknow  Lutopsy findings available  completion of cause of  s 2 No  Probably 4 □Unknow  Lutopsy findings available  completion of cause of  s 2 No  Probably 4 □Unknow  Lutopsy findings available  completion of cause of  s 2 No  Probably 4 □Unknow  Lutopsy findings available  completion of cause of  s 2 No  Probably 4 □Unknow  Lutopsy findings available  completion of cause of  s 2 No  Probably 4 □Unknow  Lutopsy findings available  completion of cause of  s 2 No  Probably 4 □Unknow  Lutopsy findings available  completion of cause of  s 2 No  Probably 4 □Unknow  Lutopsy findings available  completion of cause of  s 2 No  Probably 4 □ Unknow  Rutopsy findings available  completion of cause of  s 2 No  Probably 4 □ Unknow  Rutopsy findings available  completion of cause of  s 2 No  Probably 4 □ Unknow  Rutopsy findings available  completion of cause of  s 2 No  Probably 4 □ Unknow  Rutopsy findings available  completion of cause of  s 2 No  Probably 4 □ Unknow  Rutopsy findings available  completion of cause of  s 2 No  Probably 4 □ Unknow  Rutopsy findings available  completion of cause of  s 2 No  Probably 4 □ Unknow  Rutopsy findings available  completion of cause of  s 2 No  Probably 4 □ Unknow  Rutopsy findings available  completion of cause of  s 2 No  Rutopsy findings available  completion of cause of  completion of cause of  completion of cause of  completion of cause of  completion of cause of  completion of c

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month\_ **Physician** 1820 M 2005 err /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Northwest Hospital Randallstewn If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Funeral Date of Birth (Month, Day, Months 1 X M 2 □ F 43 Director July5,1961 Balto. 213-82-6863 Md. Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Md. Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 42 Cedarmere Road 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Machinist Tool & Die Co. 12 Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) in and 2 should be fill Health and Mental Hitem 27 is marked oth Be Harold L. BeCraft Gloria Hafele 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 le any injury or other trau once. Jennifer A. Broadwater 511 Locust Ave. Westminster, Md. 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🗆 Burial 2 💢 Cremation 3 🗀 Removal from State May 23,05 Hampstead, Md. 4 □ Donation 5 □ Other (Specify) Carroll Cremation 21. Signature of Funeral Service Licensee 11824 Reisterstown Road 22. Name and Address of Facility Eline Funeral Home Reisterstown, Md. 21136 Cir Approximate
Interval Between
Onset and Death Part1. Enter the disease, or compli<del>cations</del> that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** erebrouseu /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. the 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death

1 ✓ Yes 2 □ No 24a. Was an has autopsy parformed certificate 2□No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examino? 1 es 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Impatient 2 ER/Outpatient 3 DOA this completely filled in by the funeral 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred : After t Certification: 1 Natural 5 🗋 Pending death. investigation 1 Yes 2 No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 THomicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of entifier 29d. Date signed (Month, Day, Year) 29c. License number

DHMH 17 Rev 1/2001

State Registrar Wisham

31. Date filed (Month, Day, Year)

5401

and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

		State of Maryland / Department of Health and Mental Hygiene  1. For Amend Items 28a-f per ME, C844, 06/02/05dbb  Registrar  Registrar  Registrar  Registrar		
		1100		
Physici		1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Pay  Year  5  1  1  1  1  1  1  1  1  1  1  1  1		
/Medio		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death		
ZXXIIII		Franklin Square Hospital Rosedale Baltimore		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)		
Director		217-26-9327   1 M 2 Q F   83   Yrs.   Months Days Hours   Min.   (Months Day, Year)   April 9,1922   Maryland		
p ,		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits		
ING 21215-0036  be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or Itams 23e or 28e-f show event. I've Medical Ever in termatice rectified at	to	Maryland Baltimore Edgemere 1□Yes 2√2No		
r 28s	Director	10e. Street and Number 10f. Zíp Code 10g. Citizen of What Country?		
11 wit		3002 Ritchie Avenue 21219 United States		
dea	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.		
after or It	E	1 Never Married 2 Married 1 1 See 20 No 1 Yes 20 No Specify:		
oours ural',	d by	3 Widowed 4 Divorced Year or Dates: White		
72 h	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working)  16b. Kind of Business/Industry		
Mithir Mith	m	Elementary/Secondary (0-12) College (1-4or 5+)		
d 21215-0036 filed within 72 hours after Hygiene. pther then "netural", or Ita ant. If a Medical Everine		10 Years Homemaker Own Home  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)		
	Be	Raymond J. Foreman Reba Downey		
Maryland 21215-0036 d 2 should be filed within 72 hours af th and Mental Hyglene. 77 is marked other than "natural", or traumatic event. If a Medical Even.	2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)		
re, Maryls s 1 and 2 should f Health and Mer ltam 27 is marke other traumatic		Mr. George W. Beard (Husband) 3002 Ritchie Ave. Edgemere, Maryland 21219		
ore, No. 1 and of Health Itam 27 other to		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State		
0 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)  Westley Chapel Meth. Cem. 5/23/200 5Rock Hall, Maryland		
		21 Signature of Equipment Surviva Line 1999		
Balt permit. Departr Import any Inju		Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222		
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between		
Physician		Immediate Cause (Final Conset and Death		
/Medical		Due to (or as a consequence of):		
Examiner		Supervisely Net conditions. Arterioscleratic Corning vo-schlar Diseaset		
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
58760, icate be executed physician and s the burial-transit	Examiner	that initiated events c.		
60, be exe		resulting in death) Last  Due to (or as a consequence of):		
876 ate b hysic	licai	o.		
Box 687(  Beath certificate to a steending physical dror use as the b	Me	IF FEMALE:		
Box leath cert attending	ian/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1		
15, P.O. I	Completed by Physician/Med	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify) 9 Unknown		
that the by detace	h h	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?		
ds sign dbe	d b	Fracture of Right Tihia 10 Yes 20 No 30 Probably 4 Clunknown		
cord	ete	24a. Was an 24b. Were autopsy findings available		
Vital Records, siclan: The law requires the contilicate has been signed inector, page 2 should be continued.	m	autopsy performed?		
n: Ti ficate or, pa		1   Yes 2   No   1   Yes 2   No   25. Was case referred to medical   26. Place of Death (Check only one)		
Viii sicla cert	o Be	25. Was case referred to medical examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Cther: 4 Nursing Home 5 Residence 6 Other (Specify)		
Of Phy arthis eral c	7. To	27. Manner of Death 28a. Date of In ury 28b. Time of 10 28c. Injury at 28d. Describe how injury occurred		
Division of or Attanding Physafter death. Director: After this in by the funeral di	tio	1 □ Natural 5 □ Pending (Month, ay Year) Injury Work? 2 Ø Accident investigation 5 0 5 M 1 □ Yes 2 Ø No		
Attar Attar r dea actor	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify), City or Town, State)		
Div	Certification;	Home 221219		
Division of Vital Records, P.O. Box 68  To the Hospital or Attanding Physician: The law requires that the death certifica within 24 hours after death.  To the Funaral Diractor: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as in		29a. Certifier (Check only   Check  tha hin 24 the R	Medicai	one) and manner stated.
5 1 kg 2		29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Dey, Year)  5 1 9 (0.5)		
20		910000 14		
21		130. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Pr. Dianafan Eugooo Franklin Square Prive Baltimore, MD 21237		
Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature		
Regist		MAY 2 3 2005 Segue & Spell		
DHMH 17 Rev 1/2	2001	WILL 10 - DESCRIPTION DE PRINCIPALITA		

ORIGINAL

			1 - For State Registrar	State of Maryl			of Health a	nd Mental I	Hygiene Reg. No.	05 17161
	Division		1. Decedent's Name (First, Middle, Last)					2. Date of Month	Day	3. Time of Death
	Physici /Medio		KATHERINE J. BRYA	NT				MAY	19, 2005	6:15 P M
}	Examin		4a. Fecility Name (If not institution, give s				vn, or Location of	Death	4c. County	
			108 NEW JERSEY AVE			GLEN B		4 Hrs. a. a.		ARUNDEL
	Funeral Director		5. Social Security Number 6. Sex 216-24-5200	м 2KD F 7. Age (In)	rs. last birthday) Yrs.		ays Hours	Min. 8. Date of (Month)	Birth Day, Year) 20, 1930	9. Birthplace (State or Foreign Country) MARYLAND
	land		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Mary f sh	ţ	MARYLAND ANNE ARUN	DEL GL	EN BURNI	ΙE				1 ☐ Yes 2 🕅 No
	r 288	Director	10e. Street and Number			10f. Zip Cod	de		10g. Citizen of W	/hat Country?
	23e c	a	108 NEW JERSEY AV	E., N.W.		2106	1		UNITED S	STATES
	r dea	Funeral	11. Marital Status	<ol><li>Was Decedent Ever i Armed Forces?</li></ol>	n U.S. 13.	Was Decedent	of Hispanic Orig Cuban, Mexican,	in? (Specify Yes o Puerto Rican, etc.	No- 14. Race Blac	a - American Indian, k, White, etc.
36	or It	ьу Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 💆 No If Yes, Give		1□Yes 2X			Specify	
8	72 hours after death with the Maryland naturel; or Items 23e or 28e-f show dical Evantrat must be rudified at		15. Decedent's Educ	Year or Dates:	16a Dece	dent's Usual O	ccupation		16b. Kind of Bu	WHITE
15	C 200	plet	(Specify only highest grade	completed)	(Give	kind of work do DO NOT use re	one during most	of working	700. Kind of Bu	anie a anie da any
21215-0036	filed within I Hygiene. other then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	SALES	3			RETAIL	CLOTHING
פר		Be C	17. Father's Name (First, Middle, Last)				18. Mother	's Name (First, Mid	ddle, Maiden Sumam	θ)
<u>la</u>		To	FRANK COLLINS				STELI	LA DEMBEC	K	
Maryland	2 short and ls m	77. X	19a. Informant's Name/Relationship (Typ						imber, City or Town,	
	is 1 and of Health item 27 other tr		JOHN A. BRYANT, 3		b. Place of Dispo			EN BURNIE Date	, MARYLANI	
ŏ	o o 🖵 🕒		20a. Method of Disposition 1 XBarial 2 ☐ Cremation 3 ☐ Re	amoval from State	cemetery, crei	natory or other	place)	MAY24.		City or Town, State
Baltimore,	permit. Pag Department Important: I any injury c		4 □ Donation 5 □ Other (Specify)  21. Signature of Fune a Service L cense		CROWNSVI				-	ILLE, MARYLAND
Ba	permit. Pag Department Important: I any injury o		> Haralen		K1 42				HOME, P.A. EN BURNIE,	MD 21061
	Physician		23a. Part 1. Emer the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	A CC UT				obstrue		Approximate Interval Between Onset and Death
	/Medical Examiner		Tosailing in additiy	Due to (or as a con	sequence of):					
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence of):					
	te be executed ysician and e burial-transit	Examine	Cause (Disease or injury that initiated events							
oʻ	e exectant and arrial-ti		resulting in death) Last	Due to (or as a con	sequence of):					
8760	ate be	lical	d							
9	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Med	IF FEMALE:	N- 16						
Вох	attend attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pre	Fetal death 3	Ectopic pregna			23d. Date Mor	e of delivery oth Day Year
o.	at the de by the a tached	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	ordeam 5	_ Other (specii)	y)		_	
<u>α</u>	that ined by deta		Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause	e given in Part I.	23e. D	Did tobacco use contr	ibute to the cause of death?
Vital Records,	quires n sign ald be	ed by	Acute Respi Emphysema	ratory	Full	114		1	☐ Yes 2 ☐ No	3 Probably 4 □Unknown
00	s been si S should I	olete	Emphasema							Vere autopsy findings available
Re	e - e	Completed						F	erformed? d	rior to completion of cause of leath? ☐ Yes 2 ☐ No
ta	sicien: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place	of Death (Check or		
of V	Physicien: this certificatal director,	10	1 ☐ Yes 2 No		2 ER/Outpatier			sing Home 5X F	Residence 6 Othe	er (Specify)
n c	ng ffe	lon:	27. Manner of Death 1 Anatural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time or Injury		injury at Work?		ibe how injury occurre	bed
isio	death.	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - /	At home farm et		1 ☐ Yes 2 ☐ N		on (Street and Number	ar or Rural Route Number.
Division	after of Direction by	Certification:	4 Homicide determined	building, etc. (Sp		eet, ractory, on	lice		Town, State)	or ribrat riodle Number,
_	ours ours nerel		29a. Certifier 1X Certifying Phys	ician: To the best of my	knowledge, deat	h occurred at th	he time, date and	place, and due to	the cause(s) and mar	nner as stated.
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	edical		er: On the basis of exam and manner stated.						
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Me	29b. Signature and title of certifier		40		cense number			(Month, Day, Year)
	Λ		Jonatha l. Do	w hours		Dos	238	<i>!</i> /	MAY 20,	2005
	4		30. JUNATHANS FORMAN, CO. 1406-B CRAIN HWY.	pplepd cause of death of SUITE 304	(Item 23a) (Type, GLEN E	Print) BURNIE	MARYLAN	ID 21061		
	Sta		31. Date filed (Month, Day, Year)	2. Registrar's S	ignature					
	Registi	ar	MAY 2 3 2005	Marie	J. Aca	121				

			For State Registrar		of Maryla		artment of H rtificate of I	lealth and M Death		Reg. No.	2005	17162
	Physicia /Medic		Docedent's Name (First, Middle, L     DOROTHY MI		ARD				2. Date of De Month MAY	1 <sup>Day</sup>	2005	3. Time of Death 2:00 P M
	Examin		4a. Facility Name (If not institution, g AVALON MANOR NURSIN		umber)			Location of Death			County of Death	٧
	Funeral Director		5. Social Security Number 6. 232–78–1597	Sex 1□M 2⊠F	7. Age (In yi	rs. last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt 11/08/1	h 909	9. Birthp WEST	olace (State or Foreign TRGINIA
	the Maryland 28a-f show notified at	Director	Usual Residence of Decedent  10a. State 10b. County  W BERKELE  10e. Street and Number	Υ	10c.	City, Town or Lo				10g. Citize	en of What Cour	0d. Inside City Limits  1  Yes 2 No
35	d within 72 hours after death with the Maryland Jiene. I then "natural", or Items 23a or 28a-f show The Medical Ezaminer must be notified at	by Funeral DI	200 S. HIGH ST.  11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was De Armed F 1 Yes If Yes, G Year or		ŀ	2540	)1 ispanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14	USA 4. Race - Americ Black, White,	ean Indian,
9500-61212		Completed t	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	Education rade completed		(Give	dent's Usual Occup kind of work done o DO NOT use retired HOMEMAKER	during most of work	ing		d of Business/Ind	dustry
/land	uld be filed Aental Hyg rked other tic event,	To Be C	17. Father's Name (First, Middle, Las STANLEY F. MALA					18. Mother's Name CORABI	e (First, Middle, ELLE PROC		'umame)	
Mar	and 2 should ealth and Men n 27 is marke ier traumatic		19a. Informant's Name/Relationship CHARLES E. BEARD/S			P	.O. BOX 30,	and Number or Rura GERRARDSTO			Town, State, Zip	Code)
saitimore,	permit. Pages 1 and Department of Healt Important: If itam 2 any injury or other once.		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Spec		n State G	p. Place of Dispo cemetery, cren REEN HILL	sition (Name of matory or other plac . CEMETERY	05/21/	Date /2005		ation - City or To INSBURG,	
Balt	permit. Departri Imports any inju		21. Signature of Funeral Service Lic	1	eun	22	2. Name and Addres 327 W. KI	SS of Facility BE	ROWN FUNE RTINSBURG	RAL HOI WV 25	ME, P.O. 402	BOX 821,
-	Pnysician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on a.	each line.	erel		g, such as cardiac	1			Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate pause.	b	o (or as a cons						-	
8/60,	cate be executed physician and the burial-transit	Ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a cons	sequence of):						
O. Box 68	es that the death certifical igned by the attending ph be detached for use as th	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1□Live	utcome of predictions of predictions of predictions of the control	etal death 3	Ectopic pregnancy Other (specify)			23	d. Date of delive	ery Day Year
rds, P.	w requires that i been signed by should be deta	by	Part II. Other significant conditions	contributing to	death but not i	resulting in the u	nderlying cause giv	en in Part I.		obacco use /es 2 🗆		ne cause of death?
Vital Records,	The la ate has page 2	Completed							24a. Was autor perfo 1 \( \text{Yes}	an osy rmed? 2 No	death?	psy findings available impletion of cause of
or Vita	Physician: T this certificat ral director, pa	To Be	25. Was case referred to medical examiner? 1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \)		Inpatient 2	ER/Outpatien		4 Mursing Ho		dence 6 (	□Other (Specify	y)
Division	or Attanding after death, Diractor: After in by the funer	Certification:	27. Mann   1 Death   1 Natural   5   Pending   investigat   3   Suicide   4   Homicide   6   Could not determine	on (Mo	nth, Day Year	t home, farm, str	Wor	yat k? Yes 2 □ No		Street and		d Route Number,
_	e Hospital or 24 hours afte e Funeral Dir letely filled in	edical Ce		aminer: On the				ne, date and place, pinion, death occur				
	To the Hos within 24 hr To the Fur completely	Me	29b. Signature and title of certifier	mul			29c. Licens	0603;	/	29d. Date	signed (Month,	Day, Year)
1	11		30. Name and address of person wh	W	JR	SHET	Can C	1126	080	1	ct	ND 2124E
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 1	2005 32.	Registrar's Sig	gnature	back		Hay	~> \ (*	/	

			For Stata Registrar	State of Ma	-		ırtment tificate					giene	05	17164
	Dhini		1. Decedent's Name (First, Middle, Last)								2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physici /Medio		Charles A.	Dona	ghy, Si	r.							005	11:37 A <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give s	treet and number)			4b. City,	Town, or	Location of	of Death		4c. Cou	nty of Death	
			523 Overdale Road					Ltim					n/a	
	Funeral		5. Social Security Number 6. Sex	7. Ag	e (In yrs. last bir		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day Jan 1	Year)	9. Birth	place (State or Foreign ntry)
	Director		219-30-2714 Usual Residence of Decedent		71	Yrs.					Jan 1	2, 34	Ma:	ryland
	and		10a. State 10b. County		10c. City, Tow	n or Lo	cation							10d. Inside City Limits
	f sho	ō	Maryland n/a		Balti	imor	~							1 XYes 2 No
	28a	rect	10e. Street and Number		Larci	LINOI	10f. Zip	Code				10g. Citizen	of What Cou	ntry?
	3a of		523 Overdale Road						21229	)			USA	
	ms 2	Funeral Directo	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. V	Vas Deced	ent of Hi	spanic Ori	igin? (Spe	ecify Yes or No- Rican, etc.)	14. F	Race - Ameri	
9	after or its	Ē	1 ☐ Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 ☐ Yh If Yes, Give	No		rres,spec □ Yes 2		n, mexicar Specify:		Hican, etc.)		Black, White,	
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215-0036	natu	Completed	15. Decedent's Edu (Specify only highest grade		16a.	(Give	lent's Usua kind of wor	k done o	durina mos	t of worki	ng	16b. Kind o	f Business/Ir	ndustry
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an	d be	o Be	James W. Donaghy								Cole		/	
Maryland	2 should be f and Mental H Is marked of aumatic eve	2	19a. Informant's Name/Relationship (Ty	oe. Print)	19b	. Mailin	a Address	(Street a			I Route Numbe	r. City or To	wn. State. Zii	p Code)
<b>S</b>	and 2 sealth ar n 27 is		Diana B. Donaghy /				-				imore,	•		
ē,	- Ta=		20a. Method of Disposition		20b. Place of	f Dispo		ne of	1		ate		on - City or T	
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Baltimore,	+ 문문 등	li	21 Signature of Funeral Service License	90 0					,		obard Fi			
m	permi Depa Impo eny ir		huchuck	Jan Jan	neh	41	07 Wi	.1ker	ns Av	enue	, Baltir	nore,	Maryla	and 21229
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused	the death. Do	not ente	er the mode	of dying	g, such as	cardiac c	r respiratory ar	rest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Chron		- NF	JE	lia	100					Onset and Death  3 YEARS
	/Medical		resulting in death)		a consequence			4144	N. Helin					Janes
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	pe iis	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	OT).	7							
	and I-tran	Examlner	that initiated events resulting in death) Last		a consequence	of):								
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687	The taw requires that the death certificate be executed to has been signed by the attending physician and tayes 2 should be detached for use as the burial-transit	Physiclan/Medical		-								1000	- 1	
Вох	eath certific attending p	M/	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome								23d.	Date of deliv	ery
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	ding h. After fune	tou	1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da)	y Year)	Injury	M	8c. Injury Work	k? Yes 2.⊟		Lou. Describe II	OW IIIJUIY OO	201160	
Division	l or Attending after death. Director: Aftel in by the fune	fica	3 Suicide 6 Could not be	28e. Place of Inju	ury - At home, fa	arm, stre							mber or Rura	al Route Number,
5	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Certification;	4 Homicide	building, etc	c. (Specify)						City or Tow	π, State)		
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in		29a. Certifier  (Check only 2 Medical Exami	sicien: To the best	of my knowledge	e, death	occurred a	at the tim	ne, date an	d place,	and due to the o	ause(s) and	manner as s	stated.
	To the Hi within 24 To the Fi	Medical	(Check only 2 Medicel Exeminate)	and manner sta		novor inv	estigation,	in my op	oinion, dea	ith occurr				
	To the I within 2 To the I complet	2	29b. Signature and title of certifier	1		1	290	. License	number		2	29d. Date sig	ned (Month,	Day, Year)
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	00		30. Name and address of person who co	11	10 1	1. 0	Print)	DI	R.	il	1000	m -	1175	2)
	Sta	ite	31. Date filed (Month, Day, Year)		ar's Signature	1001	ing	rca	, UP	3 1 1 1 1	TOTICE, I	11/ 9	(10mg	0
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Phyllis Ann Decker May 21, 12:15 AM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 5 Wilbur Road Baltimore Essex 8. Date of Birth (Month, Day, Year) April 15,1935 West Virginia 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 6. Sex **Funeral** Days Hours Months Min. 232-56-5503 1 ☐ M 2 🖫 F 70 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nd Mental Hygiene. 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 7 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, the Medical Examinatings as the righted at 1 ☐ Yes 2 ☐ No Maryland Baltimore Director Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Wilbur Road 21221 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cashier Retail Sales 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be unk. Willie S. Decker ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 slument of Health and Francis Burger (Son) 2331 Foster Avenue, Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Removal from State May 25,2005 Baltimore, Maryland Bayview Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addess of a city ski Funeral Home, P.A. 21. Signature of Funeral Service License 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a. Part1. Ent 1 in a disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of high failure. List only one cause on each line. Immediate Cause (Final Hepatocellular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 Who
9 Unknown Day Month Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II\_Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Vein thrombosis 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate 1 Yes 2 No or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 ☐ Yes 2 Wolo 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation after death filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 53462 an

Registrar
DHMH 17 Rev 1/2001

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State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

7845

32. Registras's Signature

DAYWOOD

Road Glen Burnie MD 21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

am

Moneses

31. Date filed (Month, Day, Year)

amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician Dicredico Kaffaelo May 17, 2005 2:15 A /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Meridian Nursing Ctr. @ Franklin Woods Rosedale If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth 29 (Month, Day, 29ar) **Funeral №**М 2□ F Director New York 92 <del>12</del>,1912 182-18-3974 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Dundalk 1 Yes 2 No Maryland Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States Funeral 228 St. Helena Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. Armed Forces ☐Yes 2☐XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Specify þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years TV Repairman Repair Panfilo (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Concettina ဂ္ Poto DiCredico Zappecosta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 228 St. Helena Avenue Rosalie DiCredico (Wife) Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □Donation 5 ☑Other (Specify) Entombment St. Stanislaus Cem. 5/19/2005 Baltimore, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral S once. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** STARR FNG /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Dualto (or as a consequence of): many, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) physicien at s the buriat-t Box 68760 Physician/Medical the attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 | Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | 1 ☐ Yes 2 ☐ No 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 Inknown 1 Yes 2 No peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 1 🗆 Yəs 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Inpatient ဥ 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death

Natural

Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 23465 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAKWOOD ROOD Glen Burnie, MD Moneses 7845

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SALLE.

32. Registrar's Sinature

MAY 2 3 2005

Donna Davis 05-34

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01		1	For State Registrar	State of M		epartment of I C <i>ertificate of</i>			giene Reg. No. 🤈 🏔	10-	1 (20)
		_	Decedent's Name (First, Middle)	Last)				2. Date of Dea		Year	3. Time of Death
	Physicia /Medic			Donna	Day			May 16.	, 2005		7:32 P M
	Examin	er	4a. Facility Name (If not institution,			4b. City, Town, Baltim	or Location of Deat	h	4c. County	of Death	
	Funeral		Johns Hopkins Ho		ge (In yrs. last birti	day) If Under 1 Year	If Under 24 Hrs	8. Date of Birth	h Your)	9. Birthp	place (State or Foreign
	Director		218-42-6024	1□M 2XIF	60 Y	rs. Months Days	Hours Min.	July13	,1944	Wes	tVirginia
	and w		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town	or Location					10d. Inside City Limits
	Maryl	tor	MD Balt	imore		Essex					1 ☐ Yes 2 X No
	or 28e	Jirec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?
	sath w	Funeral Director	1905 Old Tu	rkey Point		212			USA - 14. Ra	ce - Ameri	can Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other than "natural", or Items 23a or 28e-f show other traumatic event, the Mucical Essa instrumatic event, the Mucical Essa instrumatic event, the Mucical Essa instrumatic event, the Mucical Essa instruments the rediffied at	5	11. Marital Status  1 □ Never Married 2  Marri 3 □ Widowed 4 □ Divorced	Armed Forces	<b>Ķ</b> No ?	13. Was Decedent of If Yes, specify Cui 1 ☐ Yes 2 ☑ No		to Rican, etc.)		ick, White,	
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pd 2	be filed within tal Hygiene. Id other than event, the Ma	Be C	17. Father's Name (First, Middle,	Last)				me (First, Middle,		me)	
ylar	should b nd Ments marked umatic e	To	Filbert L					J. Pri		Canto 7	n Codel
Maryland	d 2 sho th and th and 7 ie m traum		19a. Informant's Name/Relations  Steven Davis	nip (Type, Print) /son		Mailing Address (Stree	ANN SERVE	ged Allipes/Section 1			MD21221
	of Health item 27		20a. Method of Disposition		20b. Place of	Disposition (Name of v, crematory or other pl		Date	20c. Location	- City or T	own, State
imo	Page nent o ant: if ury or	li	1 ∰ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S			wnCemete	ry 5/	24/05	Balti		
Baltimore,	permit. Pages Department of H Importent: if ite any injury or of		21. Signature of Funeral Service	Licensee	01	22. Name and Add	ress of Facility CO	nnelly	Funera	lHom	eofEssex
	202 00		23a. Part1. Enter the disease, or shock, or heart failure. List	compleations that cause	ed the death. Don	ot enter the mode of dy	Ace Ave	Baltimo ac or respiratory a	rrest,	212	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	only one cause on each	A	iuries				5	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence						
E	Lxammer	ē	Sequentially list conditions, if any, leading to immediate	b. — Due to (or a	s a consequence of	of):				-	
	outed id ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	C							
Ő,	icate be executed physicien and s the buriat-transit		resulting in death) Last	Due to (or a	is a consequence of	of);					
58760,	physic physic s the b	edical		d							
Box (	death certifii e attending p od for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy 2  Fetal death	3 □Ectopic pregnan	icv			ate of deliv	very Day Year
	0 0 2	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 🌋 Unknown		at time of death	5 Other (specify)				OTHE	Day Toal
P.0	The law requires that the de ite has been signed by the a page 2 should be detached t		Part II. Other significant condition	ons contributing to death	but not resulting in	the underlying cause of	given in Part I.	23e. Did 1	tobacco use co	ntribute to	the cause of death?
rds,	quires n sign uld be	ed by						1 🗆	Yes 2 No	3 Pro	bably 4 Unknown
Record	e law requir has been s ge 2 should	Completed						24a. Was	psy	prior to c	topsy findings available ompletion of cause of
E B		Con						1 Yes	ormed? 2☐ No	deeth?	2 🗌 No
Vital	Physicien: Th r this certificate ral director, pag	Be C	25. Was c e referred to medica examiner?  1 2 Yes 2 No	l Hospital: 1 ☐ Inpa	itient 2 🛭 ER/Ou	tpatient 3□ DOA	\thon	eath (Check only only only only only only only only		ther (Spec	ifv)
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sion	Attending For death.  ector: After by the funer	catio	1 □Natural 5 □ Pendir 2 ☒ Accident investi 3 □ Suicide 6 □ Could	gation 5-16	-05 1	9:04 M 1	Yes 2 No	wiect-	d du	T, Na	collision
Division	i or Attendi after death Director: A i in by the fi	Certification;	3 Suicide 6 Could 4 Homicide determ	inad 200. Flace of	Injury - At home, fa etc. (Specify)	rm, street, factory, offic	90	Easter To		elQ-	ral Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1□, Certifyii	ng Physicien: To the be Exeminer: On the basis	st of my knowledge	o, death occurred at the	time, date and place	ce, and due to the	cause(s) and r	manner as	stated.
	the Horin 24 the Fu	Medical	onal	and manner	state 7		nse number	carrod at the time,	29d. Date sign		
)	5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7	29b. Signature and title of certifie	7	2001		OCME		May 17		
,	01		30. Name and address of person	who completed cause	rejeath (Item 23a)				,	,	
1	,U		PATRICIA	fron ca-	SHAK ,	√ 111 F	enn Stre	et Baltiı	more Ma	rylar	nd 21201
	St Regist	ate trar	31. Date filed (Month, Day, Year	32. Regi	strar's Signature						
DH	-IMH 17 Rev 1/2		MA	Y 23 2005	Olelia 1	of specie					
					ORI	GINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Carol Frances Ford-Voge 6.30 PM MAY 17 2000 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ST-ACNES MEALTH BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5 Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🗙 F 215-44-0688 60 Yrs. Director Mar 13. Maryland Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d, Inside City Limits 10a State 10b. County 7 is marked other then "neturel", or items 23e or 28a-f show treumatic event, the Medical Exandrat must be multiled at 1 ☐ Yes 2 No Laurel Director Maryland Prince George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14237 Jib Street #12 20707 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status should be filed within 72 hours after on Mental Hygiene. marked other then "neturel", or Iter 1 Never Married 2 Married altimore, Maryland 21215-0036 1 Tyes 2 No Specify: White þ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Car Salesperson Auto Dealership 12 permit Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 Is marked other any irriury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Sneed Ford Ethylyn Muriel Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14237 Jib Street #12, Laurel, Maryland 20707 Bruce H. Voge III - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 5/25/2005 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease on combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only only cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory **Physician** failure m onth toom /Medical Examiner acres rohns disease requentially list nondlines if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-tran requires that the death certificate be execu Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) JYes 2⊠No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an has autopsy performed: 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 😿 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 0 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide

6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number. City or Town, State)

29a. Certifier

4 Thomicide

1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatyre and title of certifier

determined

29c. License number M.D. P17600 29d. Date signed (Month, Day, Year) May 17 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MITIKIRI, St. Afnes Health Care, 900 Caton Are, Baltimore, MD 21279 DAYIRUPAMA

Registrar

Medical

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MAY 2 3 200 1 James 15 June 16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month Year 11:10 PM **Physician** 2005 May 16 /Medical 4c. County of Death Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Year) 8-19-1965 Birthplace (State or Foreign Country) Social Security Number **Funeral** 218-76-6236 MARYLand Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show other treumetic avant, the Medical Examiner must be notified at 1 Yes 2 No Baltimore Be Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 21214 USA FISROCE or Items 23a 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: BLACK Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 1 Ransportation and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden\_Surname) Anyonette RICE Joyner Romeo 19a. Informant's Name/Relationship (Type, Print) wither, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balylo. Md. 21214 ElsRode itam 27 l Antoinette JOHNER 20b. Place of Disposition (Name of cemeter), crematory or other 20c. Location - City or Town, State 20a. Method of Disposition ō <u>=</u> 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ Department of Important: If any injury or once. \* 4 ☐ Donation \_ 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Aller's MeliopolHan Chapel P. 21213 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure) List only one cause on each tine. Approximate Interval Between Onset and Death Sephic Shock

Due to (or as a consequence of); Immediate Cause (Final / disease or condition resulting in death) 24 hours Physician /Medical 36 hours **Examiner** Sequentially list conditions, if any, leading to initial educations. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner unknown Infecte physician and the burial-transit To the Hospitel or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Illness Retroviral 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 ➡Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 ☐Other (Specify) 1 ☐ Yes 2 📉 No 2 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident **Director:** 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To tha Funarel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 16 2005 RES-000

DHMH 17 Rev 1/2001

State Registrar North Carline Street Baffmore Manjan

21287

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

2005 Registrate's Signature

601

31. Date filed (Month, Day, Year)

			For State Registrer	State of Ma	ryland / Depa <i>Cer</i>	irtment of H <i>tificate of L</i>			iene eg. No. 2	0.05	17171
			Decedent's Name (First, Middle, Last	st)	***			2. Date of Deat Month		Year	3. Time of Death
	Physicia /Medic		PHILIP	COLONY	JOHNSON			May		2005	2:53 A M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County	of Death	
			129 N. Somerset A				field	D. D. J. of Birth		Somer	set
ì	Funeral		5. Sociał Security Number 6. S	ex 7.Age ⊠M2□F	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)		lace (State or Foreign
	Director		003-01-8707 Usual Residence of Decedent	21	88 TIS.			March 13	3, 1917	L Calı	fornia
	land ow		10a. State 10b. County		10c. City, Town or Lo	cation				1	0d. Inside City Limits
	Many Frah	to	Maryland Some	rset		Crisf	ield				1)⊈Yes 2 □ No
	r 28a	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Coun	itry?
	th wit	alD	129 N. Somerset A	venue			21817			USA	
	r dea	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ick, White,	
36	be filed within 72 hours after death with the Maryland ital Hyglene. d other than *natural', or liems 23a or 28a-f ahow adont, the Madical Exacilitational avant, the Madical Exacilitational to the control of the control of the control of the control of the Madical Exacilitation of the control of the contr	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give	•	1 ☐ Yes 2 ☒ No	Specify:		Speci	fy: Wh	ite
Ö	hour tural	g pe	15. Decedent's Ed	Year or Dates:	16a, Dece	dent's Usual Occupa	ation		16b. Kind of B	Business/Inc	dustry
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212	with jiene.	mo	Elementary/Secondary (0-12)	College (1-4or 5- 5+	+)	Engineer			Chemi	cal	
	e filec othe vant,	Be C	17. Father's Name (First, Middle, Last,	)			18. Mother's Nam	e (First, Middle, I	Maiden Suma	me)	
Maryland	should b ind Ments a marked umatic a	To E	Philip A. Johnson				Louise G				
lar)	2 sho and I la ma		19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	ng Address (Street	and Number or Rui	al Route Number	r, City or Town	, State, Zip	(Code)
	and ealth m 27		Philip C. Johnson	, Jr. (Son	20b. Place of Dispo	. Somerse			ield, 20c. Location		an 1 21917
altimore,	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crei	natory or other plac	ce)			•	
Ē	t. Partmen tant:		* 4 ☐ Donation * 5 ☐ Other (Specif	(y)	Salisbury	Cremator  Name and Address		1, 2005	Salisb	ury,	Maryland
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural; or Items 23a or 28a-f ahow amy injury or other traumatic avant, It a Marical Examination at the notified all once.		21. Signature of Funeral Service Licer	Blow Sin	Br Br	adshaw &	Sons Fun				
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ŀ			shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	10.	GETTC				10	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. / M (or as a	a conservance of):	CHILL	JUNE	rome		7 0	750
	Examiner			D032 (01 a3 i	a conservation or,						
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Вох	attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy Other (specify)	/			lonth	Day Year
o.	that the de ad by the a	ysic	1 Yes 2 No	9□ Unknown	time of dodd?	2 0 0 10 ( Op 0 0 11) /					
<u>α</u>			Part II. Other significant conditions	contributing to death be	ut not resulting in the u	inderlying cause giv	en in Part I.	23e. Did to	bacco use con	ntribute to t	he cause of death?
ds.	uires n sign	d by	PROSTATE	CANCE	R			1 □ Y	es 2 No	3 Prob	pably 4 □Unknown
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Vital	(0	O	25. Was case referred to medical				26. Place of Dea	th Check onl or			
$\leq$	ysic is ce direc	O	examiner? 1 X Yes 2 □ No	Hospital: 1 Inpatie	ent 2 ER/Outpatie	nt 3 DOA Oth	ner: 4 Nursing H	ome 5 Resid	ence 6 🗆 O	ther (Specif	fy)
J Of		T.T	27. Manner of Death	28a. Date of Inju (Month, Da)	ry 28b. Time o	of 28c. Injui Wor	ry at rk?	28d. Describe h	ow injury occu	urred	
0	Attending r death. actor: Afte	atic	2 Accident investigation			M 1	Yes 2 □ No				
Division		Certification:	3 Suicide 6 Could not to determined		ury - At home, farm, st c. <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tow		nber or Hura	al Route Number,
	To tha Hospital or within 24 hours afte To tha Funaral Diru completely filled in I							and due to the			tated
	a Hospital 24 hours a B Funaral etely filled	edical	29a. Certifier  (Check only 2 Medical Exe	miner: On the basis of and manner sta	f examination and/or in	th occurred at the till nvestigation, in my	me, date and place opinion, death occu	rred at the time,	date and place	, and due t	o the cause(s)
	To tha within 2 To tha complet	Med	29b. Signature and title of certifier	and marmor see	atou.	29c. Licens	se number		29d. Date sign	ed (Month,	Day, Year)
	F 3 F 8	V	Ma	AIO		D-30	9813		Mass	20,	2005
	CA		30. Name and address of person who	completed cause of d	leath (Item 23a) (Tyne		J J 4 J		ray	201	
							v - Crisf	ield. Ma	rvland	21,81	7
	St	ate	Michael At 31. Date filed (Month, Days 1991)	1 20 NSZ. Regist	ar's Signature	Arable D			<del> <u>y</u> 111 1141</del>	ent Oth	
	Regist		mat 8	A	THE SERVER	Jan Jan Jan					

			1 - For State Registrer	State of Mary	•	artmer rtificat				Reg. No.2	05	17171
	Physici	an	Decedent's Name (First, Middle, Last,     MARY CATH)	•	KEEFE				2. Date of De	9,2005	Year	3. Time of Death 10:00 Mar
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)				Location of Dea		4c. Count	y of Death	
	Funeral Director		5. Social Security Number 6. Se 214-24-3030 1L Usual Residence of Decedent	7. Age (III	n yrs. last birthday, 76 Yrs.	) If Unde Months	r 1 Year Days	If Under 24 Hr Hours Mir	8. Date of Bin (Month, Da FEB •	3, 1929	Cou	place (State or Foreign ntry) RYLAND
	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show amportant: if Item 27 is marked other than "natural", or items 23a or 28a-f show simportant: if Item 27 is marked at 500.00.	Funeral Director	10a. State		Dc. City, Town or L	IMOR	E Code 212	224		10g. Citizen of	What Cou	10d. Inside City Limits
5-0036	2 hours after deal atural', or itema	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  15. Decedent's Edu		16a. Dece	1 ☐ Yes	2 No	Specify:	Specify Yes or No orto Rican, etc.)	Speci	WH.	etc. ITE
21215	d within 7. giene. er than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	USEW	ise retired	during most of w	orking	DO	MEST	IC
Maryland	should be filed within and Mental Hygiene. s marked other than aumatic event, the Max	To Be (	17. Father's Name (First, Middle, Last)  JOSEPH MESSI	NA				ROSE		PETARRO	)	
Baltimore, Mar	Pages 1 and 2 shu lent of Health and nt: if Item 27 Is m ry or other traum		19a. Informant's Name/Relationship (T)  TOM KEEFE / SON  20a. Method of Disposition  1	Removal from State		YANK osition (Na matory or	EE I	DOODLE	DR., BE	L AIR, I	MD	21014 own, State
■ Balti	permit. Departm importa any inju		21. Signature of Funeral Service Licens  23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the	7	<u>00 S</u>	. CC	DNKLING	INC. FI ST., B.	ALTIMO:	HOM! RE,M	ED. 21224 Approximate Interval Between
8760,	certificate be executed with the continuation of the continuation	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of):  O SCLE onsequence of):	RTE ROT MEL	-16	CART	ISEASE DIOVASCI	ILAR OIS	t7+St	
P.O. Box 6	death certifi e attending id for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 MarNo 9 ☐ Unknown	23c. If yes, outcome of particles of the second of the se	Fetal death 3	□Ectopic p		,		1	ate of deliv lonth	rery Day Year
	law requires that the as been signed by th 2 should be detache	ed by Pi	Part II. Other significant conditions co		not resulting in the	underlying	cause giv	en in Part I.				the cause of death? bably 4 Unknown
l Reco	The ate h	Complet	HYPERTENSI	oN					24a. Was auto perf 1 Ves		Were auto prior to co death? 1 \( \sum \text{Yes}	opsy findings available ompletion of cause of
of Vita	Phy this	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpatie		28c. Injur	er: 4 □ Nursing	Home 5 Res			(fy)
Division of Vital Records,	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Medical Certification;	1 Matural 5 Pending 2 Accident 3 Suicide 6 Could not be determined		- At home, farm, s	M treet, facto		k? Yes 2 □ No	28f. Location City or To	(Street and Nurr own, State)	iber or Run	ral Route Number,
	n 24 hours n 24 hours ns Funera	edical (	29a. Certifier (Check only one)	vsician: To the best of r iner: On the basis of ex and manner stated	camination and/or i	ith occurred nvestigatio	d at the tir n, in my o	ne, date and pla pinion, death oc	ce, and due to the curred at the time	cause(s) and m , date and place	anner as s , and due t	stated. to the cause(s)
)	To the within To the comp	Ž	29b. Signature and title of certifier	en ny			1700	9 02 7	12	29d. Date sign		
-	21		30. Name and address of person who of	MILLER	3601	O'L	)0N/	VELL	ST. G	ALTIN	une,	MD.
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	head	4,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Mei 2005 LORETTA LAPEARL MEADE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** forth Arunde Brunse 8 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🖫 🗗 Yrs. Director 80 07/24/1924 VIRGINIA 230-38-5098 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at MD ANNE ARUNDEL 1 ☐ Yes 2 ☐ No Director HANOVER 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 7509 USA JACQWILL ROAD Funeral 21061 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes XIXNo Specify: ğ Specify: BLACK 3X Widowed 4 ☐ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry d 2 should be filed within 7. In and Mental Hygiene. 7 Is marked other than "no Elementary/Secondary (0-12) 12TH College (1-4or 5+) 3 YEARS HOUSEKEEPING HEALTHCARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be RICHARD MARTIN DAISY BARBER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If itam 27 is CAROLYN MCCREADY/DAUGHTER 7509 JACOWILL RD, GLEN BURNIE, MD 2 1 0 Date 20c. Location - City or Town, State 21061 20b. Place of Disposition (Name of MD CONTENT FRANKS Of CEM)
GARRISON FOREST 20a. Method of Disposition 1 △Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. \* 4 ☐ Donation \_ 5 ☐ Other (Specify) 5/27/05 OWINGS MILLS, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVENUE, BALTIMORE her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ready failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedial Cause (Final diseas r condition resum g in death) V mc Priysician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner 节 use as the burial-transit 0 as a con equence of) the attending physician Box 68760, Physician/Medlcal IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year detached for 4☐Pregnant at time of death 5 Other (specify) ģ been signed be should be deta Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has 2 No 1 Tyes of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending Pl
 24 hours after death.
 Funeral Director: After th Division 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tille of certifier 29c. License number

Registrar

DHMH 17 Rev 1/2001

State

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HOL

301

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E

BURIT

2 3 2005

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			1 - For State Registrar	State of Maryla			ent of H				
	Physic	ian	Decedent's Name (First, Middle, Last	)		.,,,,,,	110 01 2	Journ	2. Date of De Month	Day Y	3. Time of Death
	/Medi	cal	JAMES K. Nu	TER					MAY	18 2	2005 7:00 TM
	Exami	ner	4a. Facility Name (If not institution, give  NoRTH WCST 1+4  5. Social Security Number 6. Se	OSPITAL CEN	TER.	R	ANDA der 1 Year	LLSTOU	NC	4c. County of	+0.
	Funeral Director			M 2□F 8	O Yrs.	Month		Hours Min		y, Year)	Birthplace (State or Foreign Country)
	yland		10a. State 10b. County	10c. C	ity, Town or Lo	cation	3 /		<u> </u>		10d. Inside Pity Limits
	he Man	ector	Maryland N/	A		Ba	Himo	re			1 Dres 2 □ No
	deeth with the Maryland ms 23s or 28s-f show I must be notified at	a Dir	10e. Street and Number	sta Ave.		10f.	Zip Code	21229	1	10g. Citizen of Wh	iat Country?
5-0036	permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health end Mental Hyglene. Important: if item 27 ia marked other than "natural", or itema 23a or 28a-f ahow any injury or other traumatic avent, tra Modical Examinat must be notified at ance.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Novidowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 Types 2 No If Yes, Give Year or Dates:			cedent of His becify Cubas 2 No	spanic Origin? ( - Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc.
5-0	72 ho natur	eted	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Deced	lent's Us	sual Occupa	tion uring most of wo	dring	16b. Kind of Busi	ness/Industry
2121	filed within Hyglene. sther than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DON OC	use retired)	ang most of wo	"King	Food+	Drug Admin
Maryland	ould be fill Mental H varked oth	To Be	17. Father's Name (First, Middle, Last) Samuel Wutt	er				18 Mother's Na Amie	me (First, Middle, Elizat	Maiden Sumame)	ner
	end 2 sho ealth end m 27 is ma		19a. Informant's Name/Relationship (T) Michelle Rigs	pe, Print) by-daught-	19b. Mailin	g Addre	ss (Street a	nd Number of	Mai Route Number	or, City or Town St.	ate, Zip Code) 2/229 2Himore, Mi)
Baltimore,	Peges 1 enemonts if item		20a. Method 6 Disposition  1 Method 6 Disposition  1 Method 6 Disposition  3 DF  4 Donation 5 Other (Specify)	Removal from State	Place of Dispos	sition (N	ame of pther place	104 4	Date 126/05	20c. Location - Ci	ty or Town, State
Baitir	permit. Pege Depertment important: if important: if any injury or once.		21. Signature of Funeral Service Licens		22	. Name	and Address	of Facility Pa	Ker Fu	reral He	one P.A. 212
			23a. Part1. Enter the disease, or compl	ications that caused the dea	th. Do not ente	or the m	ode of dving	such as cardia	or respiratory ar	sattimore	Approximate
1	Physician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	cardi	[2]	In	ferc'	nb		Interval Between Onset and Death
	Examiner	16	Sequentially list conditions,	Hyp	este	-5	~d,				
Ī	ecuted and -trensit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conspi							
68760,	ficete be executed physicien and is the burlal-trensit	edical Ex		Due to (or as a consect.	quence or):						
Box 68		/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn	ancy					22d Date	f delices
o.	The lew requires that the death cert lie has been signed by the ettending bage 2 should be deteched for use a	Physician/M	in the past 12 months?  1  Yes 2  No 9  Unknown	1 Live birth 2 ☐ Fet: 4 ☐ Pregnant at time of o 9 ☐ Unknown	al death 3	Ectopic Other (	pregnancy specify)			23d. Date o Month	
<u>α</u>	uires that signed b	þ	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the un	derfying	cause given	in Part I.	23e. Did to		ute to the cause of death?
50	w requir s been sl should	lete	(190)						24a. Was a	n 24h Wei	re autopsy findings available
Division of Vital Records,		Completed							autops perfori	med? prior dear	r to completion of cause of
Z.	Physician: Tribis certificers aldirector, p	Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital:			Other		ath (Check only on		
0	g Phys er this erel di	n; To	27. Manner of Death	1 Inpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of	- 05	28c. Injury a Work?	4   Nursing H		ence 6 Other (	Specify)
ion	Attanding I or death. actor: After by the funer	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	м		s 2 □No			
Divis	tal or Attands selter death	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, larm, stre	et, facto	ry, office		281. Location (St City or Town	reet and Number on, State)	or Rural Route Number,
	To the Hospital or Attenswithin 24 hours effer deatl To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of my knowner: On the basis of examination and manner stated.	owledge, death ation and/or inve	occurre	d at the time, n, in my opin	, date and place lion, death occu	, and due to the carred at the time, d	ause(s) and manne ate and place, and	er as stated. due to the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier			25	c. License r	number	2	9d. Date signed (N	fonth, Day, Year)
	, ~>		MANN	V->		i	JOC	1527	1 28	May 23	7005,2
5	1		30. Name and address of berson who co	mpleted cause of death (Iter	n 23a) (Type, P	rint)	Phi	St	Balt	v, grans	My 21201
*	Sta Registra		31. Date filed (Month, MAY San 3	32. Registrar's Signa	ature .	284					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Joyce 01iver 18 May 2005 2:40p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 7100 Jennifer Way Sykesville Carrol1 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Yei March 18 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 💢 F 57 1948 220-50-1134 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ent of Health and Mental Hygiene.
net of Health and Mental Hygiene.
net if item 27 is marked other than "natural; or Items 23a or 28a-f show mark the hybrid that he notilised at my or other traumatic event, It's Madical Examinar must be notilised at Md Carrol1 Sykesville 1 Yos 2 □ No by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7100 Jennifer Way 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ↑ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) domestic 10 housekeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Belcher Alma Sizemore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pam Winson (caregiver) 7100 Jennifer Way, Sykesville, Md 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or once. 5-24-05 Sneedville, TN Belcher Cemetery 22. Name and Address of FacilityHaight Funeral Home & Chapel 21. Signature of Funeral Service Licensee ▶ Paige Haight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 4☐Pregnant at time of death signed by the a d be detached f Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an performed 2 No 1 ☐ Yes Hospital or Attanding Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P this After thi funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 🗌 Yes 2 No death. investigation 2 Accident Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by To the Hospital or At within 24 hours after d 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d-Date signed (Month, Day, Year) 29c. License number 29b. Signature d title of certifier

State Registrar 31. Date filed (Month, Day, Year)

Street Westminster, mo 2115

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

32. Registrar Signature

Guesses.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician 1230 AM 2005 Tay /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore
If Under 1 Year If Under 24 Hrs. University of 5. Social Security Number Maryland Medical Center
6. Sok 7. Ade Un vrs last hirthda 8. Date of Birth (Month, Day, Year) 28,53 0+ 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 17€M 2□F 52 Director 219-60-3100 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 Tyyes 2 □ No Director Md. n/a Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 238 2801 Frederick Avenue 21223 USA filed within 72 hours after death by Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Mechanic Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other treumatic event <u>once.</u> Be Frank J. Plum V Angela C. Heinėkamp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne M. Burkman / Sister 3 Beefwood Ct. Baltimore, Md. 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 5/19/05 Baltimore, Md. 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Sanature i Funeral Service Licenses 4107 Wilkens Avenue, Batimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Privsician iver tailure disease or condition resulting in death) /Medical Due to (or as a consequence of); **Examiner** patitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law r quires that the death certificate be executed use as the burial-transit that initiated events iding physician and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 🛂 📉 o 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 No 1 ☐ Yes 2 110 1 Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 140 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred iuneral 27. Manner of Death After 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the f Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide within 24 hours To the Funerel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Ericson,

31. Date filed (Month, Day, Year)

22

South Green

Baltimore, Mp

	_		1 - For State Registrar	State of M	aryland		artment rtificate			nd M		Reg. No.	2005	17	176
	Physic	ian	1. Decedent's Name <i>(First, Middle, La:</i> Ruth Neal	*							2. Date of Dea Month May		2005	3. Time of	
	/Medi Examir		4a. Facility Name (If not institution, give Westminster Nurs	e street and number,	)				Location of		пау		ounty of Death Carrol		ım M
	Funeral		5. Social Security Number 6. S	ex 7. A	ge (In yrs. la	st birthday)	If Under	1 Year	If Under 2		8. Date of Birt	h ,	9 Righ		r Foreign
	Director			□м 2ДF	78	Yrs.	Months	Days	Hours	Min.	Feb. 2	8, 19	927 VÃ	place (State o intry)	
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City,	, Town or Lo	cation							10d. Inside Cit	ty Limits
	Mary I sh	to	MD Howar	·d		Ellic	ott C	itv						1 🗌 Yes	2 1 No
	h with the	al Director	10e. Street and Number 11860 Triadelph	ia Road			10f. Zip	Code 210	)42			10g. Citize	en of What Cou USA	intry?	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "naturel", or Items 23a or 28a-f show other treumatic event, the Madical Executer rust be rufflind at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1 □ Yes 2 M If Yes, Give Year or Dates:	Ever in U.S P	1	Was Decede I Yes, speci	77	spanic Orig n, Mexican, Specify:	in? (Spe Puerto F	cify Yes or No- Rican, etc.)		I. Race - Amer Black, White Specify: Whi	, etc.	
5-0036	72 hou	ted	15 Decedent's Fr	lucation		16a. Deced	ient's Usual	Occupa	ition	of wordsin		16b. Kind	d of Business/Ir	ndustry	
2121	within 7 ene. than "r	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or	5+)	16a. Deced (Give life. I				or workin	ng				
	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, II.e M.	Col	12 17. Father's Name (First, Middle, Last)			Sel	f Emp			's Name	(First, Middle,		oduce		
lan	should be to not Mental I i marked of umatic eve	To Be	Luther Joel M								Will		,		
Maryland	2 shou and M Is mar eumat		19a. Informant's Name/Relationship (	Турө, Print)	- 1	19b. Mailin	g Address	(Street a					Town, State, Zi	o Code)	
	ges 1 and 2 t of Health If item 27 or other tre		Mr. Samuel V. Pap	a (Son)	001 01								ty, MD		
Jore	0 = 5		20a. Method of Disposition 1 Paurial 2 Cremation 3 C			nce of Dispo					ate /2005		ation - City or T		<b>5</b> TD
Baltimore			<ul><li>'4 □ Donation 5 □ Other (Specify</li><li>21. Signature of Funeral Service Licer</li></ul>	-	Cres						)/2005		iottsv:		ID
ä	permit. Departr Importe eny inju		Duan X4	lught		TH S	AIGHI	111c	IERAT"	10ME	. & СНА. 34 (410	PEL, \_705	PA (Box	(195)	
N. Control	Physician		23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that cause one cause on each	d the death.								1400	Approximate Interval Bety Opiset and D	veen
	/Medical Examiner		resulting in death)  Sequentially list conditions.	b. Other to 16 at	a conseque	ence of):	retu	· l	asc	ulv	~ Dis	eus		25gr	
7	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):	for l		P	· Ln	-01-	Q.	ani.	704	4
8760,	death certificate be executed eattending physician and of for use as the burial-transit	cai Examiner	that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):	eus	e-	- / 0		T	V		-3 <i>y</i>	
9	rtificate ng physi as the l	Medi	IF FEMALE:	0											
Ó. Box	at the death certific by the attending p tached for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal o	death 3	Ectopic pre Other (spe	gnancy cify)				23	d. Date of deliv Month	•	'ear
rds, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions o	ontributing to death b	out not result	ting in the ur	nderlying ca	use give	n in Part I.			bacco use	contribute to t	he cause of de	
Il Records,	The ate h page	Completed								_	24a. Was a autop perfor	sy	24b. Were auto prior to co death? 1  Yes	ppsy findings a mpletion of ca 2 \( \text{No} \)	vailable use of
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe		of Death	(Check only or	ne)			
of	ing After unel	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	iry 2	R/Outpatien: 28b. Time of Injury		c. Injury Work	4 Nurs	28	e 5 🗌 Resid 8d. Describe h		Other (Special	(y)	
Division	el or Attending s after death. Il Director: After id in by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj	iury - At hon c. (Specify)	ne, farm, stre					8f. Location (S City or Tow		Number or Rura	al Route Numb	oer,
	To the Hospitel (within 24 hours a To the Funeral D completely filled i	edical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best niner: On the basis o and manner st	f examination	ledge, death on and/or inv	occurred a restigation, i	t the time in my op	e, date and inion, death	place, ar occurred	nd due to the c d at the time, c	ause(s) ar	nd manner as s ace, and due to	tated. the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1010			29c.	License	number		2	29d. Date s	signed (Month.	Day, Year)	
	2/0/		John W.Y	nildlet	n y	nn		)	254	43		511	0/200	25	
6	10		30. Name fild address of person who a state of the W. Mid 31. Date filed (Month, Day, Year)	deton	HD	23a) (Type, i	Pook	RR	oad,	WA	Am ins	ter,	MD	4157	7
	Sta Registr		S. Date filed (World), Day, 19di)	2005	ar's Signatu	K A	Rocks					,			

			1 - For State Registrar	State	of Maryla		artmen <i>rtificat</i>				ental Hyg	giene Beg. No. 201	15	17	177
	<b>.</b>		1. Decedent's Name (First, Middle,	Last)							2. Date of Dea	ıth		3. Time of	f Death
	Physici /Medio		JAMES						PAUL	L	Month MAY	,	Year	7:30	D PM
	Examir		4a. Facility Name (If not institution,	give street and nu	ımber)		4b. City,	Town, or	Location of	of Death		4c. County of			
			JOHNS HOPKINS I	BAYVIEW	HOSPIT	AL	RALT	IMO	RE A	ARY	LAND	N/A			
	Funeral			S. Sex		s. last birthday)			If Under	24 Hrs.	8. Date of Birth			place (State of	or Foreign
	Director		216-10-3186	1 <b>反</b> M 2□F	95	Yrs.	Months		Hours	Min.	(Month, Day Sept. 2	, Year)	Cour	ntry)	or i oraigir
			Usual Residence of Decedent						!		sept. Z	9,1909	Gec	orgia	
	/lanc		10a. State 10b. County		10c. C	City, Town or Lo	ocation						1	I0d. Inside C	ity Limits
	Man 1 sh	ţ	Manusland Dala						ъ		l 1_			1 🗆 Yes	2 <b>N</b> o
	the 28a	Director	Maryland Balt  10e. Street and Number	cimore			10f. Zip	Code	D	unda]		10g. Citizen of W	at Cour	ntny?	
	with with			Dond			101121		21	222				,	
	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show disal Examinar must be notified at	Funeral	1901 Sunberry		edent Ever in	116 12	Mac Dane	dont of U		222	-4 - V N -	United			
	lterr	Ľ,	11. Marital Status	Armed F	orces?	0.5.	If Yes, spec	offy Cuba	n, Mexicar	gin? (Spec n, Puerto P	cify Yes or No- Rican, etc.)	14. Hace Black	- Ameno , White,	can Indian, etc.	
36	rs aff	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, G	2 ☑ No ive		1 🗆 Yes	2⊠ No	Specify:			Specify:			
21215-0036	houl fural		21	Year or [	Jates:	10- D	dante Herri	10						nite	
7	"na"	Completed	15. Decedent's (Specify only highest			16a. Dece	kind of wo DO NOT us	rk done d	turina mos	t of workin	g	16b. Kind of Bus	iness/Ind	dustry	
12	within ene. than "	E D	Elementary/Secondary (0-12)	College (	1-4or 5+)				,						
	e filed within al Hygiene. I other than ' vent, I'le My		6 Years				Steel	Norke						dustry	
in contract of the contract of	be fi	Be	17. Father's Name (First, Middle, La									Maiden Sumame	)		
<u>₹</u>	should nd Men marke umatic	ို	James Davi	d Paul							Jane Ca				
Maryland	01 00 00 00		19a. Informant's Name/Relationship									r, City or Town, S		Code)	
	of Health item 27		Mr. James M. I	Paul (So	on)	816	Stile	es Ct	t. J	oppa,	Maryla	and 210	85		
Baltimore,	of He		20a. Method of Disposition			Place of Dispo cemetery, cres	sition (Nan	ne of ther plac	e) 1	Da	ate	20c. Location - C	ity or To	wn, State	
Ĕ	Page ent c nt: If ry or		1 Burial 2 Cremation 3		State	Gardens	-	-		. 5/2	23/2005	Rosed	ale.	Mary	land
<b>=</b>	permit. Pages. Department of Inportant: If ite any injury or of		21. Signature of Funeral Service Lig		0										
Ä	permi Depa Impo any ir		1000	1 /	110							Dundalk,			
		_	23a. Pan1. Enter the disease, or co	omplications that	raused the des	ath Do not ent	er the mod	se F	ve.	Dund	lalk, Ma	aryland	212	22 Approximat	
10			snock, or neart failure. List or	ity one cause on	each line.	an. Donoton	or the mod	o or dylin	y, such as	cardiac or	respiratory arr	651,		Interval Bet	ween
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a HYI	OXEMI	A							N	NE DA	
	/Medical Examiner		resulting in death)	Due to	(or as a conse	quence of):									1.12
6	LAGITITICI		Sequentially list conditions	b. CAV	enio myo	PATHY							ጥ	WO YEA	mg
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a conse	quence of):									
	cute nd rans	Examin	Cause (Disease or injury that initiated events	c. INT	ER STITT	AL LUN	4 DISE	ASE					F	IVE YEA	ms
oʻ	an a	EX	resulting in death) Last	Due to	(or as a conse	quence of):									
8760,	cate be executed physician and the burial-transit	dicai		d											
9	tifica ng ph as th	led		750							· · · · · · · · · · · · · · · · · · ·				
Вох	n cer andir use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregr		e					23d. Date	of delive	ry	
m	death a atte	icia	in the past 12 months?		oirth 2 Fet nant at time of		Ectopic pro Other <i>(sp</i> e					Mont	1	Day 1	Year
o.	the by the ache	Jys	9 🗆 Unknown	9□ Unkn	own										
<u>α</u>	Physician: The law requires that the death certif this certificate has been signed by the attending, ral director, page 2 should be detached for use as	y P	Part II. Dther significant conditions	s contributing to d	eath but not re	sulting in the u	nderlying ca	ause give	n in Part I.		23e. Did tot	pacco use contrib	ute to th	e cause of d	leath?
Vital Records,	uires Isign	d by	STROKE								1 🗆 Ye	s 2 🗆 No 3	☐ Proba	ably 4 💢 t	Jnknown
Š	w require been sign should t	ete									-				
ě	The tav	Completed									24a. Was a autops	V DI	or to con	osy findings a npletion of ca	available ause of
=	ician: Th certificate ector, pag	S									perform 1 Yes 2	neg? ge 2 <b>∑</b> No 1E	ath? ] Yes	2□ No	
<u> </u>	ysician: is certific director,	Be	25. Was case referred to medical examiner?							of Death (	(Check only on	e)			
<del>o</del>	Physi this c	2	1 ☐ Yes 2 XNo	Hospital: 1X	Inpatient 2	ER/Outpatien	t 3 🗆 DO	A Othe	r: 4 □ Nui	rsing Hom	e 5 🗆 Reside	ence 6 Other	(Specify	)	
0	ding Ph h. After th funeral	ü	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28	8c. Injury Work	at ?	28	Bd. Describe ho	w injury occurred			
<u>ō</u>	ath. Pr: Al	atle	2 Accident investigat	tion			М		es 2□N	No					
Division	Atte	iffic	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	288. Place	of Injury - At h	nome, farm, str	eet, factory,	, office		28	Sf. Location (St.	reet and Number	or Rural	Route Num.	ber,
	s afte	Certification;	104411000	Dulid	ing, etc. <i>(Spec</i>	(Y)					City or Town	i, Statė)			
	Spit hour nere y fille	a	29a. Certifier X Certifying	Physician: To the	best of my kn	owledge, death	occurred a	at the tim	e, date and	d place, an	nd due to the ca	ause(s) and manr	er as sta	ated.	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical	(Check only 2 Medical Ex	aminer: On the b	asis of examin ner stated.	ation and/or inv	estigation,	in my op	inion, deat	h occurred	at the time, da	ate and place, an	d due to	the cause(s)	)
	o th o th omp	Me	29b. Signature and title of certifier				29c.	License	number		2:	9d. Date signed (	Month, E	Day, Year)	
	F S F O		) C				RE	· - 0 e	0 0			1A4 18, 20		,,,	
1	11/	-	, , ,			D			-		10	10120	US		
1	)[		30. Name and address of person wh							C					
1			SUSAN CHENG ,	JOHNS H	OPKINS B	AYVIEW }	NOSPITA	TL, A	1940	EASTE	RN AVEN	UE, BALTI	nore	, MD, 2	21224
	Sta Registr		31. Date filed (Month, Day, Year)	723 200	egistrarySign	ature &	A STATE OF THE PARTY OF THE PAR	1 sept							
	ricgisti	al.	ALCO AND AND AND AND AND AND AND AND AND AND	TAU LUUI	A. 18 E S S S S S S S S S S S S S S S S S S	ACID OF	6 B								

			For State Registrar	State of Maryland / Dep	partment of Hertificate of L			jiene	05	17178
	Physicia	an	Decedent's Name (First, Middle, Last)		oist		2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic Examin	al -	4a. Facility Name (If not institution, give st			Location of Death	May 19		ity of Death	7:38A M
	Examin	ei	7414 Bayfront Road		Edge	emere		Ва	ltimor	e Co.
	Funeral Director		5. Social Security Number 6. Sex 1 ☑ 6. Sex	7. Age (In yrs. last birthday M 2 F 75 Yrs.	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Dec . 2	, Year)	Cour	place (State or Foreign ptry) Land
	and		Usual Residence of Decedenl  10a. State 10b. County	10c. City, Town or I	Location				1	0d. Inside City Limits
	Maryl	ţō	Maryland Baltime	ore	,	Edgemere				1 ☐ Yes 24 ② No
	th the or 28a e noti	Director	10e. Street and Number	_	10f. Zip Code	21219		l0g. Citizen o	f What Cour	ntry?
	s 23e	rait	7414 Bayfront Ro		. Was Decedent of Hi		aitu Vas ar Na		d Sta	
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23e or 28a-f show any injury or other treumetic event. It is Marylaid Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	2. Was Detected 1 2 2 1 11 0.3. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1955–57	If Yes, specify Cuba	Specify:	Rican, etc.)		lack, While,	
Maryland 21215-0036	72 hou	Completed	15. Decedent's Educ (Specify only highest grade	ation 16a. Dec	edent's Usual Occupa re kind of work done of DO NOT use retired	ation during most of working	ng	16b. Kind of	Business/In	dustry
121	within ane. then "	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		" icklayer		Stee	l Indu	ıstrv
р 2	filed Hygie other	Be Co	12 Years 17. Falher's Name (First, Middle, Last)	FC	oreman Br	18. Mother's Name	(First, Middle,			ABCL Y
ylar	Menta Menta Brked etic ev	To B	Samuel B. Poist				Lucill			
Mar	12 sho h and 7 is m		19a. Informant's Name/Relationship (Type Mrs. Virginia A. P		iling Address <i>(Street a</i> l Bayfront		<i>l Route Numbe</i> gemere,	_		21219
ē,	thealt tem 2 other	i	20a. Method of Disposition	20b. Place of Disi			ate	20c. Location		own, Slate
E	Pages nent of ant: If i	,	1 🔀 Burial 2 □ Cremation 3 □ Re  '4 □ Donation 5 □ Other (Specify)	emoval from State	Mem. Gdns	1 .	05	Bel A	ir, Ma	aryland
Baltimore,	permit. Departr Importe any inju		21. Sunature of Funeral Service License	' <i>(/(</i> ) T	22. Name and Addres Ouda-Ruck 1922 Wise	Funeral H	ome of dalk, Ma	Dundal arylan	k, Ind	2. 2.22
	**	7	23a Part1. Enter the disease, or complic shock, or heart failure. List only on		nter the mode of dyin	g, such as cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	Pnysician /Medical	1	Immediate Cause (Final disease or condition resulting in death)	Lung Cancer					0:	3/10/05
	Examiner			Due to (or as a consequence of):						
	P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Observation of the cause (Dispase of Injury	Due to (or as a consequence of):						
_	and and I-trans	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence of):						
8760,	icate be executed physician and s the burial-transit	dical E	d							
9	rtificati ng phy i as the	Medi	IF FEMALE:							
Вох	death certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant at time of death 5	B Ectopic pregnancy Other (specify)	/	<u>.                                    </u>		Date of delive Month	ery Day Year
P.O.	that the de ed by the detached	hys	9 Unknown	9□ Unknown			00 014		. 9	
	vrequires that the death certific seen signed by the attending f hould be detached for use as	by	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause giv	en in Part I.				he cause of death?
Vital Records,	has 6.2	Completed					24a. Was autop	med?	prior to co death?	opsy findings available impletion of cause of
tal	10	0	25. Was case referred to medical			26. Place of Death		2 <b>%</b> No	1 ☐ Yes	2 □ No
	di is	To B	examiner? 1 ☐ Yes 2 💢 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	ient 3 DOA Oth	er: 4 Nursing Ho	me 5X Resid	ence 6 🗆 C	Other (Specia	(y)
on of	ding h. After fune		27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury 28b. Time (Month, Day Year)	/ Wor		28d. Describe h	ow injury occ	urred	
Division	or Attendater death Director: /	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		28f. Location (S City or Tow		mber or Rura	al Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical C	29a. Certifier 1 Certifying Phys	in an: To the best of my knowledge, de ler: On the basis of examination and/or and manner stated.	ath occurred at the tir investigation, in my o	me, date and place, a ppinion, death occurr	and due to the o	cause(s) and date and plac	manner as s e, and due t	stated. o the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier		29c. Licens			29d. Date sig	ned (Month,	Day, Year)
	1		1/1/1/	7		5065		lay 19,	2005	
V	X1/18		30. Name and address of person who co Universi	ty of Maryland GCC	22 S. Gre	eene St NS			e, MD	21201
	Sta Regist		31. Date filed (Month, Day, Year)	2 3 2005 Minimum	" Sparke	1				

			1 - For State Registrar	State of M		d / Depa		of H	ealth a		lental Hygi	iene	) 0 5	17181
	Physic /Medi	cal	Decedent's Name (First, Middle, Ruie R.      Racility Name (If not institution,	Raby	ar)		4b. City, T	own or	Location	of Death	2. Date of Death Month May 21	Day		3. Time of Death 12:30A M
	Examile Funeral Director	ier	4814 Ridge Road		Age (In yrs. la	ast birthday) Yrs.	If Under 1	Mt.	Airy If Under		8. Date of Birth July 13	Carro	11 C	County  place (State or Foreign
	ס	tor	Usual Residence of Decedent  10a. State 10b. County  MD Carro	11		Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 🏋 No
	s 23a or 28	Funeral Director	10e. Street and Number 4814 Ridge Road				10f. Zip (	21	771			g. Citizen of \USA		
900	nours after de urai', or item Exercilier i	b	11. Marital Status  1 □ Never Married   3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Force: 1	s? ]No	1	Was Decede f Yes, specif 1 ☐ Yes 2		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		k, White,	can Indian, etc. hite
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exercitive must be routiled at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4o	r 5+)	(Give life. L	tent's Usual kind of work DO NOT use Carper	done d retired)	urina most	of worki	ng	66. Kind of Bi		dustry
ryland	should be filed with and Mental Hygiene. Is marked other than aumatic event, ILE	To Be (	17. Father's Name (First, Middle, La John Raby  19a. Informant's Name/Relationshi,			19h Mailin	Address /		N	letti	e (First, Middle, M.e. Moore	<u> </u>	,	Code
	ies 1 and 2 s of Health an of tem 27 is or other trau		Mrs. Nettie Raby  20a. Method of Disposition  1 XBurial 2 Cremation	(Spouse)	20b. Pla	4814 ace of Dispo	Ridge sition (Name natory or oth	Roa	d Mt.	Air	y, MD 21			
Baltimore,	permit. Pages 'Department of H Important: if ite any injury or ot		' 4 □ Donation 5 □ Other (Special Service Li	censee	Pir	ne Gro	Name and AIGHT	Addres FUN	s of Facility ERAL	HOME	& CHAPI	It. Air EL, PA	(Box	
	Fnysician /Medical		23a. Part1. Enter the disease, or constitution shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	omplications that caus	79/	ence of):	or the mode	of aving	(VII)	21 /8 cardiac o	r respiratory arre	- / 95 <b>- 1</b> / <sub>1</sub> st,	00	Approximate Interval Between Orset and Death
8760,	Examiner be executed bhysician and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disase of 1747) that initiated events resulting in death) Last	b. Due to (or	s a conseque	ence of):								
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d.  23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal	death 3	Ectopic pred					23d. Dat	e of delive	ery Day Year
Records, P.	w requires that been signed t should be det	by	Part II. Other significant condition	s contributing to death	but not resul	Iting in the ur	nderlying cau	rse dive	n in Part I.			cco use conti	ibute to th	ne cause of death? nably 4 Unknown
Vital Rec		e Completed	25. Was case referred to medical						00.00		24a. Was an autopsy perform	90? QNo 1	Vere auto rior to cor eath?	psy findings available impletion of cause of 22 No
o	ng Phys fter this neral di	ToB	examiner? 1 Yes 2 No  27. Manner of Peath 1 Natural 5 Pending investigal			R/Outpatient 28b. Time of Injury		Other	. 4 🗆 Nur	sing Hon 2	(Check only one ne 5 X Residen 8d. scribe hov	ce 6 □Othe		v)
Division		Certification	3 Suicide 6 Could no determin	building,	etc. (Specify)					li.	8f. Location (Stre City or Town,	State)		
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical	29a. Certifier 1 Certifying (Check only one)  29b. Signature and title of certifier	Physician: To the best aminer: On the basis and manner s	of examination	on and/or inv	estigation, ir	n my opi License	nion, deatl	h occurre	d at the time, dat	e and place, a	nd due to	the cause(s)  Day, Year)
\	0		30. Name and address of person with	no completed cause of	death (Item	23a) (Type, F	Print)	D -	139	7/	1 Frede	5/2/	105	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regis	TYPCO	orch, U	Social Social	a (	HUSPI	Tal	INEAR	nace,	NID	

		For State		State of	Maryla	ind / Depa		of He	ealth a	and M	lental Hy		2005	17181
		Registrar  1. Decedent's Nam	na (First Middle	(ast)		Cer	lilicate	OIL	Jean		2. Date of De	Reg. No		3. Time of Death
Physic											Month	Da		
/Medi Exami		Margare  4a. Facility Name		Reitemeye			4b. City, T	own, or	Location of		May 21		. County of Dea	7:30 p M
LAGIIII	iei	Carroll			,		Westr					1	rroll	
Funeral		5. Social Security I		S. Sex	7. Age (In yı	s. last birthday)	If Under			24 Hrs. Min.	8. Date of Bird (Month, Da			rthplace (State or Foreign
Director		217-34-6		1 □ M 2 🛣 F		98 Yrs.	MOUNTS	Days	Hours	Willi.	April 2	28,1	907 MI	)
and		Usual Residence of	10b. County	<del></del>	10c. (	City, Town or Lo	cation							10d. Inside City Limits
Manyl f sho	ror	MD	Baltimo	re		kesvill								1 ☐ Yes 2½ No
r 28a	rec	10e. Street and Nu	ımber				10f. Zip (	Code				10g. Cit	izen of What C	Country?
h witi	Funeral Director	ll Waldr	on Avenu	.e			2120	80				USA		
ams ams	iner	11. Marital Status		12. Was Dece		U.S. 13.	Vas Decede	ent of His	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	-	14. Race - Am Black, Wh	
or it	by Fu		ried 2 Marrie	d 1 ☐ Yes If Yes, Give	2√∑ No		∏Yes 2		Specify:		11.04.1, 010.)		Specify:	ne, etc.
hours tural, o	d be	3 Widowed	15. Decedent's	Year or Da	tes:	16a. Deced	loot's I laval	000000	tion			105 10	Wr	nite
in 72 in 72	plet		cify only highest	grade completed)		(Give	kind of work DO NOT use	k done di retired)	uring mos	t of worki	ng	16D. K	ind of Business	s/industry
d with giene	Completed	Elementary/Sec	ondary (0-12)	College (1-	4or 5+)		ewife					Own	Home	
d be file of othe	BeC	17. Father's Name	(First, Middle, La	ast)					18. Mothe	er's Name	(First, Middle,	Maiden	Sumame)	
Tar yidilid XIXIS-0050 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene Is marked other than "natural", or Itams 23a or 28a-1 show aumalic event, the Mydical Excupler matter in tilled at	2	Roy Capl	e						Rose	Kimm	ney			
2 shot and ls m		19a. Informant's N		_	<b>a</b> -		-						or Town, State,	. ,
Mey Mich		Mr. Bern.		ursier	Son						Owings		1s, MD	
Defitimore, Interpretation AIA 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the World Examiner marker in titled at once.		1 TyBurial 2	☐Cremation 3	B □Removal from S	nais	. Place of Dispo cemetery, cren			- 1	Mav	24			
DallIIIIOI  bermit. Pages Department of mportant: If it any injury or o	17	21. Signature of F	5 ☐ Other (Spe uneral Service Li		Dr	uid Rid	ge Cer . Name and			2005	-		esville	
Dermi Depa Impo any i			m	de	inc		ine Fu				Reiste:		terstow	m Ka.
		23a. Part1. Enter	the disease, or c	omplications that candy one cause on ea	used the de	eath. Do not ente	er the mode	of dying	, such as	cardiac o			WII IID	Approximate
Pnysician		Immediate Cause	(Final	niy one cause on ea	icri line.	(	D							Interval Between Onset and Death
/Medical		re offing in death)	Ori	a Due to	ras a cons	equence of):	reu	LVYC	avua					lon
Examiner		Sequentially list of	onditions.	b. Ser	ere	Daso	her	ver	0					3mg
ed is	ine	Sequentially list of any, leading to it cause. Enter Und Cause (Disease of that initiated eventions)	mmediate erlying	Due to (d	or as a cons	equence of ()	C	)						^
xecu and and li-train	Examiner	that initiated event resulting in death)	s Last	c. Due to (c	or as a cons	equence of):	estr	u						Cerny
law requires that the death certificate be execu ed as been signed by the attending physicien and 2 should be detached for use as the burial-tra sit	ical E					- 1								
ificate g phy: as the	ed			0										
is, F.C. DOX OC res that the death certifica igned by the attending ph be detached for use as to	Physician/M	IF FEMALE: 23b. Was deceded	nt pregnant	23c. If yes, outo	ome of preg		Ectopic pre						23d. Date of de	alivery
death	sicia	in the past 12	No		ant at time of		Other (spe				<del></del>		Month	Day Year
at the d by the etach	Phy	9 Unknow												
signe bed	by	Part II. Other sign	iricant condition	s contributing to de	ath but not r	esulting in the ur	iderlying ca	use givei	n in Part I.		23e. Did ti		4	to the cause of death?
w require been si	Completed										-			
<b>a c a</b>	mpi										24a. Was autop perfo		24b. Were a prior to death?	completion of cause of
	ပိ	25. Was case refe	red to medical						00 PI	- 15	1 Yes	2/2 No		s 2 No
on or vitaliding Physician: h. After this certific	0 B	examiner?	No.	Hospital:	patient 2	☐ ER/Outpatien	t 3 🗆 DOA	Othe			(Check only o		6 ☐Other (Spe	acifu)
g Phy g Phy ter this	n:	27. Manner of Dea		28a. Date o				c. Injury Work			28d. Describe I			sony)
anding sath. or: Afte	atio	Natural 2 Accident	5 Pending investiga	tion	, buy rour,	injury	М		′es 2 🔲 l	No				
or Att fter de iract n by t	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	286. Place	of Injury - At g, etc. <i>(Spe</i>	home, farm, streety)	eet, factory,	office		2	28f. Location (5 City or Tox			lural Route Number,
pital o		20- 2	~ C											
To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one)	Medical E	Physician: To the miner: On the ba and mann	past of my k	novnedge, death ation and/or inv	occurred a restigation,	t the time in my opi	e, date an inion, dea	d place, a th occurre	and due to the and at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
Fo the vithin Fo the	Me	29b. Signature and		1				License					te signed (Mon	th, Day, Year)
/ > = 0	/	<b>)</b> (	//	21			D	37	94	a		Mu	~ 23M	n 200x
617		30. Name and add	ress person	m completed cause	of eath (It	em 23a) (Type,	Print)						0"	n 2005 m, 2457
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	ate	31. Date filed (Mo.	nth, Dayl (an)	2 30 20 03 Re	gi <b>strar</b> 's Sig	nature	September 1	Sec. Marie						
Regist	Tal						4.5	. 11						

		For State		State	of Mary		partme ertifica				lental Hy	1	1005	1	7182
		Registrar  1. Decedent's Name (First)	, Middle, La	st)	7	,	erunca	ile oi i	Jeani		2. Date of De.				Time of Death
Physic /Medi		Bry	na	F	Kud-	zin					Month May	/8	2002	5 8	: 15 AM
Exami	ner	4a. Facility Name (If not in: HOWARD COU		e street and n ENERAL	<sub>umber)</sub>	TAI		y, Town, or UMBIA		of Death			County of Dea	ath	
Funeral	_	5. Social Security Number	6. S			yrs. last birtho		er 1 Year	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da		9. B	rthplace	(State or Foreign
Director		099-32-7619 Usual Residence of Deced		UM 2K1F		63 Yrs	. Workin	Days	Tiodis	141111.	04/29/1	1942		N	1.J.
yland how			County		100	c. City, Town o	Location								nside City Limits
8a-fs	ctor		OWARD			COLUME									☐Yes 2√ No
with th	Dire	10e. Street and Number 5931 CEDAR	EEDN	COLIDT				<sup>2ip Code</sup> 21044				10g. Cit	izen of What C		
death	Funeral Director	11. Marital Status	FLKN		cedent Ever	in U.S.	3. Was Dec	edent of Hi	ispanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	-	14. Race - Am Black, Wh		dian,
ite, INICAL FICALISTONSO  8.1 and 2 should be filed within 72 hours after death with the Maryland I Health and Menial Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-f show other treumatic event, the Modical Examinator results and	by Fu	1 ☐ Never Married 2  3 ☐ Widowed 4 🛣 Di	_		2 <b>∑</b> No ive			2 X No	Specify:		rticali, etc.,		-	ite, etc. WHIT	E
2 hour	ted b	15. De	ecedent's E	ducation		16a. D	cedent's Us	sual Occupa	ation			16b. Ki	ind of Busines	s/Industry	y
vithin 7	Completed	Elementary/Secondary (			(1-4or 5+)	li	ive kind of v e. DO NOT	use retired	during mos ()	t of work	ng				
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should be filed with not Mental Hygiene. I marked other that umatic event, train	To B	NORMAN				GINS	BURG		SYL	.VIA		BLC	OMBERG		
2 sho 2 sho 1 s ma 1 s ma reuma	ľ	19a. Informant's Name/Re					151				Al Route Numbe				9)
is 1 and 30 Health ltem 27 other tr		JAY RUDZIN  20a. Method of Disposition		HUSBAND		Db. Place of D	sposition (N	ame of	1		D COLUM		MD 21		State
Pages nent of I ont: If It		1 X Burial 2 □ Cren `4 □ Donation 5 □ 0			n State (	cemetery, CEDAR F	crematory`o			5/20	/2005	EME	RSON, N	.J.	
DaltifillOr permit. Pages ' Department of the Importent: if its any injury or ot once.		21. Signature of Juneral S	ervice Licer	age C	111		22. Name	and Addres	s of Facilit	y SOL	LEVINS	ON 8	& BROS.	, IN	IC.
		23a Part 1 Foter the dise	ase or com	nlications that	Caused the	death Do not				-	OAD - P		SVILLE,		21208 roximate
Physician	ı	23a. Part1. Enter the dise shock, or heart failur tmmediate Cause (Final disease or condition	e. List only	one cause on	each line.	ntri	1100	1	Filox	0111	ation	1031,		Inter	rval Between et and Death
/Medical Examiner	П	resulting in death)		a Due to	o (or as a cor	nsequence of).	uuc	t t	COR	-1116	Cuco (			/	muce
LAMINIE	e.	Sequentially list conditions	rsaquanea of):	41											
cuted	Examin	if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events	" <b>【</b>	c.		,									
icate be executed physician and sthe burial-transit	i Exa	resulting in death) Last	- 1	Due to	o (or as a cor	rsequence of):									
ficate to physic to the b	edlcai			d											
The law requires that the death certific the law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	an/M	IF FEMALE: 23b. Was decedent pregn		23c. If yes, o	utcome of probirth 2		3 □Ectopic	огеолалсу					23d. Date of de		
the att	Physician/M	in the past 12 month: 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	s?		nant at time		5 Other (						Month	Day	Year
that the ned by detac	by Ph	Part II. Other significant	ondition	ontributing to	death but no	t resulting in th	e underlying	cause give	en in Part I.		23e. Did to	obacco u	use contribute	o the cau	use of death?
w requires the signs should be.		my e/	2 d	15pl	LSIA	<u> </u>					101	/es 2(	□No 3□F	robably	4 Unknown
2 a a a	ompleted	· Va:	5 CU/1	415							24a. Was autop	sy	prior to	completi	ndings available ion of cause of
VICION: The certificate rector, pag	e Cor	H	nem	IA							1 Yes		death?	s 201	No
ystcie ystcie is certi directo	0 B	25. Was case referred to examiner?  1 Yes 2 100	rieulcai	Hospital: 1	Inpatient	2 ER/Outpa	tient 3 🗆 🗈	Othe Othe	200		n <i>(Check only o</i> me 5 ☐ Resid		6 □Other (Sp.	ecify)	
ding Physicien: The h, After this certificate h tuneral director, page	on: T	27. Manner Death	Pending	28a. Date (Mo	e of Injury nth, Day Yea	28b. Tim Inju	У	28c. Injury Work	at c?		28d. Describe h				
uttend death ctor: /	ficati	2 Accident 3 Suicide 6 S	investigation		e of tniury	At home, farm	M street facto		Yes 2 1	-	28f. Location (S	Street an	d Number or F	lurai Rou	ite Number
s after	Certification;	4  Homicide	determined	buil	ding, etc. (Sp	pecify)		,,			City or Tox	vn, State	)		
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical (	29a. Certifier 1 C (Check only 2 M	ertifying Ph edical Exar	niner: On the	basis of exar	knowledge, d	eath occurre	d at the tim on, in my op	ie, date an pinion, dea	d place, th occurr	and due to the e	cause(s) date and	and manner a f place, and du	s stated. e to the c	cause(s)
To the vithin 2	Med	29b. Signature and title of	certifier	and ma	nner stated.	2 0	2	9c. License	number			29d. <b>Da</b> t	te signed (Mon	th, Day,	Year)
/		· ///			1111	· L.		00	57	78	3, 1,	MCC	4/8	, 6	2005
25		30. Name and address of	erson who	completed car	use of death	(ttem 23a) (Ty	oe, Print)	00	tive	ON	top,	1111	1/2/1	inh	a mo
'St	ate	31. Date filed (Month, Day	Year)	32.	Registrar's S	Signature	1118	ru	wxc	110	120	ny	Colli	1101	
Regist		MAY 2 3	2005	Account		4 1.	w .					0			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day **Physician** 2005 2:00 May 17. Gertrude /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick

If Under 1 Year

Months Days Northampton Manor Nursing Home Frederick Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days 1□M 2XF Hours Min Feb. 8, Director 91 1914 Maryland 215-20-7842 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23s or 28s-f show the Medical Exeminer must be indiffed at 1 Yes 2 □ No Director Maryland Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21701 USA 319 Adam Road within 72 hours after death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumating. College (1-4or 5+) Elementary/Secondary (0-12) retail sales lady Department Store 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Sarah Catherine Lambert Franklin L. Bachman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4742 Teen Barnes Road, Frederick, MD Carl Rentzell, Jr., son 20b. Place of Disposition (Name of cemetery, crematory or other place) 5/19/2005 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Resthaven Memorial Gardens Frederick, Maryland A □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Keeney and Basford Funeral Home 21. Consture of Funeral Service Licenses 21701 M00999 106 East Church Street, Frederick, MD Irace Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or read failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Deard Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician for use as the buria ician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown Physi 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death out not resulting in the underlying cause given in Part I. þ Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 🕅 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 2 28a Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred 28b Time of al or Attending P s after death. Il Director: After I 5 Pending 1 Tyes 2 No investigation 2 🗀 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital o within 24 hours aft 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of contitier anc D58391 May 17, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sajjed Aziz, MD, 801 Toll House Avenue, C-3, Frederick, Maryland 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 1 2005 Registrar

LEWIS SMITH 05-03517 RKD

			For State Registrar	State of M	larylan		artmen			and Me		giene Reg. No.		
ı	Physici /Medic		Decedent's Name (First, Middle, Las     LEWIS FERNA	SMITH						N	. Date of Dea Month	- 4 1	005	3: Time of Death 3:10P. 0 m
	Examin	er	4a. Facility Name (If not institution, give 4800 ELDORADO AVE				BAL	TIMO				4c. Count		·
	Funeral Director		5. Social Security Number 6. Social Security Number 1. Social Security	9X 7. A	71	last birthday) Yrs.	If Under Months	Days	If Under Hours		Date of Birt (Month, Da ARCH 2	h, Year) 1934	9. Birth	place (State or Foreign htry)  SC
	ne Maryland Ba-f show	Director	10a. State 10b. County  MD BALTIMO	RE		y, Town or Lo								1 Yes 2 No
	with the or 2	Dire	10e. Street and Number 6723 BROMPTON ROA	D			10f. Zip	2120	3.7			10g. Citizen of USA		ntry?
036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other then "netural", or liems 23e or 28e-f show marked other then "netural", or liems 23e or 28e-f show maric event. The Medical Ecana at miret be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 X Yes 2  If Yes, Give Year or Dates	? ] No		Was Deced f Yes, spec	lent of Hi cify Cuba		gin? (Speci n, Puerto Ri	fy Yes or No- can, etc.)	- 14. Ra	ce - Americ	etc.
Maryland 21215-0036	filed within 72 ho Hygiene. other then "neturent, Its Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		5+)	life.		rk done d	urina mosi	t of working		16b. Kind of E		dustry
yland 2	should be filed ind Mental Hyg s marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last)  ARTHUR SMITH			110				er's Name (i		Maiden Sumai		
Mar	S ar ar		19a. Informant's Name/Relationship (7 STANLEY SMITH/SON				ng Address 2 W. I					MORE, M		AND 21223
altimore,	Page nent o ant: If ury or		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☑  '4 ☐ Donation 5 ☐ Other (Specify	)	a   0	Place of Disponentery, crer	natory`or o APT . CI	ther place H . CEN	1.	5-27	<b>-</b> 05	20c. Location UNION,	SC	
Ba	permit. Departn Importe any inju		21. Signature of Funeral Service Licen	im	orti					S ST.				S F.H.,INC. LAND 21217
	Physician /Medical Examiner		23a. Part, Enter the disease, or come shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	a	1100 405	clere	œ .		9000	cardiac or r	7	disec	Se.	Approximate Interval Between Onset and Death
8760,		dical Examiner	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Cue to (or a c. Due to (or a		,								
O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	Ideath 3	Ectopic pro						ate of delive	ary Day Year
٥.	w requires that been signed b should be deta	by	Part II. Other significant conditions of	ontributing to death	but not res	ulting in the u	nderlying c	ause give	ın in Part I.			obacco use con ∕es 2 □ No		ne cause of death?
al Records,	The ate h page	Completed									24a. Was autop perfo 1 XYes	an 24b. esy rmed? 2 \( \subseteq No \)	Were auto prior to co deatb?	psy findings available mpletion of cause of 2 No
Viital	sicien: Th certificate irector, pag	o Be	25. Was case referred to medical examiner? 1 ★ Yes 2 □ No	Hospital:		500		Othe			Check only o			
Division of	ding Ph h. After th funeral	1-	27. Manner of Death  1 Natural 5 Pending investigation	1 ☐ Inpat 28a. Date of In (Month, D	jury	28b. Time of Injury		8c. Injury Work	4 🔲 Nu	28	5 🗌 Resid	dence 6 (XOth		SCENE
Divis	i ji fe	Certification:	3 Suicide 6 Could not be 4 Homicide determined	289. Place of I	njury - At h	ome, farm, str y)	eet, factory	, office		28	f. Location (5 City or Tox	Street and Numi vn, State)	ber or Rura	d Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dii completely filled in	edical	29a. Certifier  (Check only one)  1 ☐ Certifying Ph  2 ☑ Medical Exam	ysician: To the bes niner: On the basis and manners	of examina	owledge, death ition and/or in	n occurred vestigation,	at the tim , in my op	e, date an pinion, dea	d place, and th occurred	at the time.	cause(s) and m date and place,	anner as s and due to	tated. the cause(s)
	To the within 2 comple	W V	29b. Signature and title of certifier	Jupm C	F	Slad	290	. License				29d. Date signe MAY 22,		
1	04/		30 Name and address of person who dark cla Aro	completed cause of	death (Iter	n 23a) (Type,	,	.1 Pe	enn St	treet	Balt	imore,	Maryl	and 21201
	Sta Registi		31. Date filed (Month, Day, Year) MAY 23 2	005 32. Begis	trar's Signa	ature	made s							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items# 18&19a per FH C851 1/5/06 CC Health and Mental Hygiene

For Amend Item 23a per Verb/Dr., 684 0 July 15

Registrar Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** May 16, 2005 4:20 /Medical Susie Anna Spann A 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital

Social Security Number 6. Sex 7. Age (In yrs. last birthday) Takoma Park

If Under Year | Trunder 24 Hrs. | 8. Date of Birth (Month, Day, Year) Montgomery

9. Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🔀 F Yrs. Director 29. Virginia 577**-**34**-**7592 79 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show the Medical Examiner must be nutified at 1 X Yes 2 ☐ No Director Washington, D. C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene important: If Item 27 is marked other than "natural", or Items 23a say jingry or other traumatic event, the Medical Examinar means once. 20017 4819 7th Street, N. E. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Internal Revenue Service Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Marie I. Lawson Maria Irene Brown Abraham Lawson 19a. Informant's Name/Relationship (Type, Print)
Maria O. Meletionship (Type, Print)

Maria O. Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 Delafield St. N.E. Washington D.C. 20017 ace of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State \* 4 □ Donation 5 □ Other (Specify) Ft. Lincoln Cemetery May 20, 105 Frentwood, MD. 22. Name and Address of Facility Latney's Funeral Home e f Fungral Service Licensee 21. Signaty 3831 Georgia Ave. N. W. Wash. D. C. 20011 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pullus 1000 pullus Due to (or as a consequence of): Physician disease or condition resulting in death) /Medical Examiner Lypoyla Sequentially list conditions, if any, leading to immediate the sequence of the Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Pneumothorax attending physician and for use as the burial-transi Tura Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnag 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Year Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. 9□ Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Onknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s has autopsy performed certificate 1 Yes 2 🖸 the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA P 1 ☐ Yes 2 ☐ No 1 Inpatient this After this 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural М 1 ☐ Yes 2 ☐ No death. Director: 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours af le Funeral D letely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date Signed (Month, Day, Year) 2 0 05803 30. W me and address of person who completed cause of death (Item 23a) (Type, Print) Kimberly Treat, MD 31. Date filed (Month, Day, Year) 3 2003 Registar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item 7 per fh G843 5-23-05 tas Amend Item 5 per fh G846 Certificate of Death 8-19-05 tasseg. No. ? 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 **Physician** Yay /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death Examiner Md. Wicomico isb ic 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. 7. Age (In yrs. last birthday) Under 1 1 Year Days Birthplace (State or Foreign Country) 6. Sex **Funeral** Hours 1 □ M 2 X F Director Jan.4,1922 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10h County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exemple; must be notified at 1 ☐ Yes 2 No Funeral Directo Maryland Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1162 Ocean Parkway 21811 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien Important: if Item 27 is marked other the any injury or other them. 12 U.S. Government Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) last Frederick William Discher (UNK.) Natalie Helen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donald Lewis (Son) 1162 Ocean Parkway, Ferlin, Maryland 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 14 Surial 2 ☐ Cremation 3 ☐ Removal from State Gardens Of Faith May 24, 2005 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Press of Facility Ski Funeral Home, P.A. 1407 old Eastern Avenue, Essex, Maryland 21221 21. Signature of Funeral Service Licenses 23a. Part1. End the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in earl failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease r condition resulting in death) CARCINOMA **Physician** LUNGS 3 YRARS /Medical **Examiner** 2 WARZIE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-tran ed by the attending physician and detached for use as the burial-tra-Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by tall Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? No D 1 Yes 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0052410

13

State 31. Date filed (Mor

GITUAM WAK (5 2 31. Date filed (Month, Day, Year) 32. Regist

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrary signature

30 Seque & Specific

			For State of Maryland		rtment of Healt			ene . No.2. 0 0 5	17187
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physicia /Medic		Jouis W Stau	hitz			Month May	17 200	h.4
	Examin		a. Facility Name (If not institution, give street and number)		4b. City, Town, or Locati	_		4c. County of De	
			3637 Hernwood Road		Woodstock			Baltimo	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. /ai $X = 14-5010$	st birthday): Yrs.	If Under 1 Year If Un Months Days Hou	nder 24 Hrs. urs Min.	B. Date of Birth (Month, Day, Y Aug. 28,	9. B 1913	inthplace (State or Foreign Country) MD
L			Usuel Residence of Decedent				11ug. 20,	1715	
	iryian ihow	_		Town or Lo					10d. Inside City Limits
	Sa-f s	octo	MD Baltimore		Woodstock			0.00	1 □Yes 2 No
	with ti	Funeral Director	10e. Street and Number 3637 Hernwood Road		10f. Zip Code 2116	63	109	. Citizen of What 0 USA	Country?
	Jeath The 23	era	11 Marital Status 12. Was Decedent Ever in U.S	. 13. \	Was Decedent of Hispanic f Yes, specify Cuban, Mex		ify Yes or No-	14. Race - An	
396	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28e-f show or other traumatic avant, it a Micdical Examinatic ust be multified at	by Fun	Armed Forces?  1 Never Married 2 Married 1 X Yes 2 No  1 X Widowed 4 Divorced Year or Dates:	1	f Yes, specify Cuban, Mex I □ Yes 2 <mark>∑</mark> No <i>Spe</i> e		ican, etc.)	Black, Wh	
Maryland 21215-0036	72 hor	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupation kind of work done during i	most of working	16	b. Kind of Busines	s/Industry
21	ithin ne.	ald I	Elementary/Secondary (0-12) College (1-4or 5+)	`life. I	OO NOT use retired)			7 <del>-</del>	
121	Hygien Hygien Ther ti nt, Ith		4 17. Father's Name (First, Middle, Last)	Carp	enter 18. M	fother's Name	(First, Middle, Ma	Carpentry	
and	d be f	To Be	Louis William Staubitz, Sr.				zabeth U		
ary	2 should be filed v n and Mental Hygie is marked other raumatic avant, II	F	19a. Informant's Name/Relationship (Type, Print)		ig Address (Street and Nu				
	and 2 lealth a m 27 is		Mr. Louis Raymond Staubitz (Son	2844	Nicodemus 1	_		er, MD 21	157
Baltimore,	Pages 1.		V Burial O Complian 3 Domewal from State COI	netery, crer	sition (Name of natory or other place) npel Cemeter	y 5/20/		c. Location - City of andallsto	
Balti	permit. Page Department of Important: If any injury or once.		21. Signatura of Funeral Service Licensee	HÃ Sy	TGHT TONERA kesville, M	L'HOME D 21784	& CHAPEL (410)-7	PA (Bo 95-1400	x 195)
	Physician /Medical Examiner	niner	23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	IVE once of):	TEMM	7 /	REMUN SEMUN	C	Approximate Interval Between Onset and Death 25 Jacys
8760,	death certificate be executed attending physician and buf for use as the burial-transit	dical Examin	that initiated events resulting in death) Last C. Due to (or as a consequence of the cons	ence of):					
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Ö	tt the death by the atte tached for	Physician/Me	230. Was observed in Pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
rds, P.	quires that in signed t uld be det	by	Part II. Other significant conditions contributing to death but not resul	ting in the u	nderlying cause given in P	Part I.	23e. Did tobac	200	to the cause of death?  Probably 4 □Unknown
Records,	The law requires that the sate has been signed by the page 2 should be detache	Completed					24a. Was an autopsy performe	prior to	
Vital	ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?			Place of Death	(Check only one)		
of	Physician: this certific ral director,	ြ	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ E	P/Outpatier	The state of the s		e 5 Fesidence 8d. Describe how	ce 6 □Other (Sp	pecify)
nc	dlng F h. After funer	tlon	1⊮ Natural 5 Pending (Month, Day Year)	28b. Time o Injury	f 28c. Injury at Work?  M 1 \sum Yes		od. Describe now	injury occurred	
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)	To th withir To th comp	Me	29b. Signature and title of certifier    Machine ATRANNII	Vin	29c/ticense numl	390	29d	Date signed (Mod	nth. Day, Year)  2 EV I
	Sta	ate_	30 Name and address of person o completed cause of death (Item  31. Date filed (Month, Day, Year) 32. Registrar's Signature.	8M	Print) DM 1173	266	WINGS	Muss,	1004/17
	Regist		TAY 2 3 2005	15.	Allender	· · · · · · · · · · · · · · · · · · ·			

Frank R. Shaulis Jr 05-3 AKC

Provision (Models)  Examiner  1400 blx (Sees Hamburg Street  1	3525					delible ink. Ensure	•	•	1 80 1 8 8		
Prank Richard Shaulis, Jr.    According to the State of Controlled Shaulis   According to State   According to Sta	3		•					5000	17188		
Properties   1400 bit Nest Hamburg Street   Baltimore   200 months		/Medic	cal	Frank Richard			May 21,	2005	1		
Description of the property of		LAAIIII	iei								
To Street and Number    100. Country   100. (From on Location   100. Incidence   100. Incid				220-02-8830 1 <sup>-1</sup> XM 2 <sup>-1</sup> F			8. Date of Birth (Month, Day, Ye Apr. 25,	9. Birthr 1983 Com	place (State or Foreign		
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Sykesville, MD 2184 (410) = 795-1400  23. Part. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final Immediate Cause) (Final Cause) (Enter Indian) (Final Cause) (Final C	ore,		1 3	20a. Method of Disposition	20b. Place of Dispo cemetery, crea	matory or other place)	1				
23a. Part : Enter the disease, or complication and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Rina) and continuous contributions or excellent in the disease. The condition of the cause of t	Baltim permit. Pa	Departmen Important: any injury once.			Crestlawn Mem. Gardens 5/26/2005 Maneral Service Licensee  Crestlawn Mem. Gardens 5/26/2005 Maneral Service Licensee  22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPI						
Proposed a control of the second of the seco				23a. Part1. Enter the disease, or complication that shock, or heart failure. List only one cause on	caused the death. Do not en- each line.	ter the mode of dying, such as cardia	ac or respiratory arrest,	793-1400	Interval Between		
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25. Was case referred to medical examiner?  1	O. Box (	y the attending ched for use a	ysiclan/Me	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No	birth 2 ☐ Fetal death 3 ☐ gnant at time of death 5 ☐			1	•		
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The street bounds of the stree	Vita	s certifi director	0 8	examiner?	Inpatient 2 ER/Outpatie	Othor		6 XIOther (Specif	at scene		
29a. Certifier (Check only 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  A PRICE AND LAND 111 Penn Street Baltimore, Maryland 2		une une		27. Manner of Death 1 Natural 5 Pending		Fun 38c. Injury at Work?			,		
29a. Certifier (Check only 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  A PRICE AND LAND 111 Penn Street Baltimore, Maryland 2	Division	after deat Diractor: d in by the	ertifica	3 Suicide 6 Could not be 28e Plan	ce of Injury - At home, farm, st	reet, factory, office	City or L wn, St	late! . I			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Atricia Aron, ca-Pollak mo 111 Penn Street Baltimore, Maryland 2	Hospits	24 hours a Funara etely fille		(Check only 2 Medical Examiner: On the	ne best of my knowledge, deat basis of examination and/or in	h occurred at the time, date and place					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Atrica Aron, ca Pollak mo 111 Penn Street Baltimore, Maryland 2	Tothe	within To the	Me		Dan.						
TATICICA MONION TOTAL	5	1			01111	Print) 111 Popp Stre					
Registrar MAY 2 3 2005					123						

DHMH 17 Rev 1/2001

ORIGINAL

/Medi	ian	Decedent's Name (First, Middle, L							2. Date of I	Death Dar 19	Y	Year	3. Time of Death
		Robert W.	Sanchuk,			_			May			2005	13:13
Exami	ner	4a. Facility Name (If not institution, g Sinai Hospital	ive street and numbe	er)	4b. City,		Location of			40.	. County	y of Death	
Funera!		-	Sex 7.7	Age (In yrs. last birtho		1 Year	If Under	24 Hrs.	8. Date of 8	3irth .		9. Birthp	place (State or Fore
Director		219-71-5194 Usual Residence of Decedent	1⊠M 2□F	0 Yr	s. Months	Days	Hours	Min.	March	Day, Year) 18,20	005	Cour	MD
land ow		10a. State 10b. County		10c. City, Town o	or Location							1	Od. Inside City Lim
the Marylan 28a-f show	to	MD Balti	more		Owings	Mi1	1s					i	1 ☐ Yes 2 📉
death with the Maryland	Director	10e. Street and Number			10f. Zip					10g. Cit	izen of	What Cour	ntry?
23a o	D E	2031 Greensprin	ng Vallev	Road		211	17				U	SA	
ours after death with the Maryla al', or Items 23a or 28a-f shov Extraiter mast be mailled at	Funeral	11. Marital Status	12. Was Deceder Armed Force		13. Was Deced	dent of Hi	spanic Ori	igin? (Spe	ecify Yes or I	Vo-		ce - Americ	
after dea or Items		1 X Never Married 2 ☐ Married		□No	1 ☐ Yes		Specify:		riicari, etc.)			ick, White,	etc.
72 hours after natural', or Ite	d b	3 Widowed 4 Divorced	Year or Dates	s:		223110	opoony.				Specif	W. W	Mite
permit. Pages 1 and 2 sho lid be filled within 72 hours Department of Health and Nental Hygiene important: If item 27 is marked other than "natural", any injury or other traumasic event, the Medical Exis page.	Completed by	15. Decedent's (Specify only highest g	Education grade completed)	(0	ecedent's Usua Give kind of wor	rk done d	luring most	it of worki	ing	16b. K	ind of B	Business/In	dustry
within	m du	Elementary/Secondary (0-12)	College (1-4o	or 5+)	ife. DO NOT us Non		)					37./·	
Hygic Hygic ther 1	ပိ	17. Father's Name (First, Middle, Las	st)		Non	.e	18. Mothe	er's Name	(First, Mida	lle Maiden	Sumar	N/A	
d be antal	00								ı Sans			,	
mark mark	J.	Robert W. Sanc		19b. N	Mailing Address	(Street a					or Town	State. Zin	Code) 2111
d 2 s Ith ar 27 is trau		Robert W. Sanch			31 Gree								
1 аг Неа tem		20a. Method of Disposition	uk, 51. 18	20b. Place of D					Date	-	-	- City or To	
ages ant of t: If i		1 XBurial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec		10	ints' C			5/2/	1/05	Ro	ict	ereto	wn, MD
permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lic		AII Sa	22. Name an		-						wn Road
Depa Impo any ir		Hopken	M Uo	ukins	Eline			Charles and pro-		sters			201 2012112020
		23a. Part1. Enter the disease, or co	mplications that caus	sed the death. Do not		-							Approximate
		shock, or heart failure. List on Immediate Cause (Final	ly one cause on each	i line.					. ,				Interval Between Onset and Death
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/Wedleat		resulting in death)	о		ed Deat	th in	Infa	ancy(	(SUDI)				0.000 0.000
/Medical Examiner			о	as a consequence of)		th in	Infa	ancy(	(SUDI)				0.1334 4110 250211
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		1	For State Registrar	State of	Marylar		artmen			and M	ental Hy	giene Reg. No. 20	05	17190
			Decedent's Name (First, Middle	, Last)							2. Date of Dea	ath	may wyy	3. Time of Death
	Physicia	an		Hazel	I	rene	Sor	ners		j	Month May	Day 18, 20	Year O.5	4:35 A <sup>M</sup>
	/Medic		4a. Facility Name (If not institution	give street and numi			· · · · · · · · · · · · · · · · · · ·		Location of	of Death	ridy	4c. County		
	Examin	er	Genesis Heritag			Ctr	12. 0.13,		dalk					ore Co.
			5. Social Security Number			last birthday	) If Under		If Under	24 Hrs.	8. Date of Birt			
	Funeral			1 □ M 200 F		Yrs.	Months	Days	Hours	Min.	(Month, Day	y, Year)		place (State or Foreign ntry)
	Director		220-05-3910 Usual Residence of Decedent		84						June_1	9,1920	Mai	ryland
	and		10a. State 10b. County		10c. C	ity, Town or L	ocation							10d. Inside City Limits
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	be filed within 72 hours after death with the Maryland tal Hygiene id other than "natural", or terna 23a or 28e-f ehow avent, if a Medical Eranical must be notified at	ral	1 E Turtle Co						2121			Unite		
	r de	Funeral	11. Marital Status	12. Was Deced	es?	J.S. 13.	Was Deced If Yes, spec	lent of Hi cify Cuba	ispanic Ori n, Mexicar	igin? (Spe n, Puerto	cify Yes or No- Rican, etc.)	Blac	e - Amen ck, White,	can Indian, , etc.
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b	New Year	Be	17. Father's Name (First, Middle,	Last)					18. Mothe	er's Name	(First, Middle,	Maiden Suman	10)	
<u>a</u>	should be f marked of matic ave	2	Robert Betti	S					L.	ula	V.	Raines		
Maryland 21215-0036			19a. Informant's Name/Relationsl	nip (Type, Print)		19b. Mail	ing Address	(Street a	and Numbe			er, City or Town,		p Code)
	and 2 ealth a n 27 is	j	Mr. John P. So	mers (Hus	sband)	1 E	Turt	Le Co	ourt	Edge	emere,	Maryland	3 2]	1219
ē,	ges 1 and t of Healt If item 2 or other	1	20a. Method of Disposition		1	Place of Disp	osition (Nar	ne of	al l	0	ate	20c. Location -	City or T	own, State
2	6 0		1 □xBurial 2 □ Cremation 1 □ Donation 5 □ Other (S)			arkwoo				/21/:	2005	Dal+ir	mo.ro	, Maryland
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			( ) segon	CICE		th Daniel	7922					Marylar	<u>id</u> 2	1222 Approximate
	Prrysician /Medical Examiner	er	23a. Part1. Enter the disease, or shock, or heart fature. List Immediate Cause. (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. Due to (c	r as a conse	quence of):	MA		0 F	E	REA	TZH		Interval Between Onset and Death MC MTHS
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P.0	g g g		Part II. Dther significant condition	ns contributing to dea	ath but not re	sulting in the	underlying o	ause give	en in Part I	l.	23e. Did to	obacco use cont	ribute to I	the cause of death?
Records,	sign sign d be	d by									101	res 2 No	3 Prof	bably 4 Unknown
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Division	death. ctor: Al	atle	2 Accident investig	ation			M	1 🗆 '	Yes 2 🗌	No				
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	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Medical (		g Physician: To the Exeminer: On the ba	sis of examin									
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	10		30. Name and address of person	who completed cause	m dealh lite	om 489) (Type	Print)	-) [[	0 1	R	CUL	E VIII	SILV	MAG
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			Please Type or Print in Black in		•	_
			State of Maryland / Dep	partment of Health and N e <b>rtificate of Death</b>		711115 17101
			Registrar  1. Decedent's Name (First, Middle, Last)	stillicate of Death	2. Date of Death	g. No. 3. Time of Death
	Physici		MARION A SIMMONS		Month	Day Year 10:15AM
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Bon Secour Hospital	Baltimore		NIA
г	, Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day, )	9. Birthplace (State or Foreign Country)
	ס		Usual Residence of Decedent		DEC. SO,	1948 Maryland
	show	<u>_</u>	10a. State 10b. County 10c. City, Town or I			10d. Inside City Limits 1 ✓ Yes 2 ☐ No
	Ne Ma	ecto	MD NA Baltimor		40.	
	with t	Funeral Director	1821 W. Favette St.	10f. Zip Code 2/223		g. Citizen of What Country?
	death ms 23	nera	1 4 7 7 7 7	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian,
9	after or Ite	/Fui	1 Never Married 2 Married 1 Yes 2 No	1 Yes 2 No Specify:	Hican, etc.)	Black, White, etc.
5-0036	72 hours after death with the Maryland neturel', or Items 23e or 28e-f show disal Exantrate must be notified at	Completed by	32 Wildowed 4 Divorced Year or Dates:	edent's Usual Occupation		6b. Kind of Business/Industry
215	n "ne	plete	(Specify only highest grade completed) (Giv	e kind of work done during most of work DO NOT use retired)	ting	
212	d within giene.	Com	Elementary/Secondary (0-12) College (1-4or 5+)	se Keeping	- 1	Hote/
	be filed Ital Hygi Id other event, I	To Be (	17. Father's Name (First, Middle, Last)	- d. D.	e (First, Middle, Ma	alden Sumame)
Maryland	should nd Men marke umatic	2	James H. Legins  19a. Informant's Name/Relationship (Type, Print)  19b. Mai	ling Address (Street and Number or Rui	Harrison	City or Tourn State Zin Code
Ma	ith an		Edith Legins - mother 3016	· ·	Dalla.	nd 21215
ē,	of Hea		20a. Method of Disposition 20b. Place of Disposition		-	Oc. Location - City or Town, State
m	Page nent c ant; If ury or		1 Burial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  Western	Cemetery 5-24	-05 R	Utimore, mo
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Evantment be routiled at Once.			22. Name and Address of Facility	neral Hon	ne P.A.
	40 = 0 d		23a. Pur prite the lisease, or complications that caused the death. Do not en			
			23a Put Intel the Isease, of complications that caused the death. Do not en shock or leaf failure. List only one cause on each line.  Immediate C use (Final	itel the mode of dyllig, such as caldiac	or respiratory arres	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  a	na		
	Examiner.		Sequentially list conditions by aucreat	ic Man		
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	- 4		
_	and II-trans	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last  C. Due to (or as a consequence of):	spoly		
760,	death certificate be executed e attending physician and of for use as the burial-transit	calE	d			
99	that the death certificate ed by the attending phys detached for use as the	ledic	0.			
Вох	th cert tendin r use	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	☐Ectopic pregnancy		23d. Date of delivery
.O. E	ne dea the at hed fo	/sict	in the past 12 months?  1 Disc 2 No 9 Munknown  1 Unknown  1 Disc 2 No 9 Munknown	Other (specify)		Month Day Year
Δ.	The law requires that the site has been signed by the bage 2 should be detache	by Physiclan/Medi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e, Did toba	acco use contribute to the cause of death?
Records,	puires that n signed h ild be det				1 ☐ Yes	2 No 3 Probably 4 Unknown
00	aw requir s been si 2 should	olete			24a. Was an	24b. Were autopsy findings available
Re	ding Physicien: The lav h. After this certificate has funeral director, page 2	Completed			autopsy perform	prior to completion of cause of death?  No 1 ☐ Yes 2 ☐ No
Vital	cien: ertifici actor,	Be	25. Was case referred to medical examiner?		h (Check only one)	
of	Physicien: this certific ral director,	. To	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie  27. Manner of De th 28a. Date of Injury 28b. Time		ome 5 Residen	ce 6 Other (Specify)
on	Attending in death. ector: After by the funer	tion	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	Log. Describe non	injury december
Division	or Attendi after death. Director: A in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	net and Number or Rural Route Number,
Ö	Hospitet or A 24 hours after Funerel Directely filled in by	Cert	Duranty, d.c. (epochy)		ony or rown,	514.0)
	To the Hospitel or Attent within 24 hours after deat To the Funerel Director: completely filled in by the	edical	29a. Certifier Certifying Physician: To the best of my knowledge, dea (Check only one)	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cau red at the time, date	ise(s) and manner as stated. e and place, and due to the cause(s)
	To the within 2 To the Complet	Mec	one) and manner stated.  29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, Day, Year)
	1	/	> Jews	1)00539	781	5/19/
1	1		30. Name and address of terson we completed cause of death (Item 23a) (Type	Print) DOSS	6.1.	3m Beltonove (M)
	Sta Regista		31. Date filed (Month, 9 and Year) 05 32. Registrar's Signature		·····	7 300

			For 1 State	State of Mary	-				0001	
_			Registrar  1. Decedent's Name (First, Middle, Last.		Ce	rtificate of l	Jeath	2. Date of Death	g. No.	3. Time of Death
Н	Physici	an	(1)	11:11	(0,-			Month		2/ HO ANA
	/Medic		4a. Facility Name (If not institution, give	street and number)	TO	4b. City, Town, or	1 ocation of De	ath I	4c. County of E	Death
1	Examin	er	MILLENNIUM HEALT		FR	FI I	ICOTT C		io. oodin, o, c	HOWARD
	Funeral		5. Social Security Number 6. Sec	7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 H		9.	Birthplace (State or Foreign
	Director		216-03-7145	M 2□F	88 Yrs.	Months Days	Hours Mi	rs. 8. Date of Birth (Month Pay, 12/07/.	1916	MD MD
	nd ,		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo					10d. Inside City Limits
	anyła shov	7	,	100	•					1 ☐ Yes ♀☐ No
	the M	Director	MD HOWARD  10e, Street and Number		COLUMBIA	10f. Zip Code		10	g. Citizen of Wha	
	with			ADT #220		21044			U.S	
	Jeath The 23	Funeral	6336 CEDAR LANE	12. Was Decedent Ever	in U.S. 13.		ispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race - /	American Indian,
9	or iter	Fur	1 Never Married 2 Married	Angred Forces? 1 ☑ Yes 2 ☐ No	MM II	If Yes, specify Cuba 1 ☐ Yes 2 No	n, Mexican, Pue Specify:	erto Rican, etc.)		Vhite, etc. WHITE
03	ral', c	d by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	33	1 Yes 2LINO	<i>Specify:</i>		Specify:	777
21215-0036	72 h	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occup- kind of work done	during most of w	vorking 1	6b. Kind of Busin	ess/Industry
121	within ne. han	m du	Elementary/Secondary (0-12)	College (1-4or 5+)	SALES	DO NOT use retired CM	1)		FURNITU	DE.
	filed within 72 hours after death with the Maryland Hygiene. that than "natural", or items 23a or 28a-f show int, the Madical Exeminar must be nutilised at		17. Father's Name (First, Middle, Last)		JALL.	או יעויונ	18. Mother's N	ame (First, Middle, M		IVE
lan	ld be ental ked o	To Be	LOUIS		Sł	HILLER	ESTHE	R		LONDON
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If itam 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Madical Exerciper must be nutified at	-	19a. Informant's Name/Relationship (T)	rpe, Print)	_		and Number or	Rural Route Number,	City or Town, Sta	te, Zip Code)
	1 and 2 Health a am 27 is		FERN TAYMAN / DAU	IGHTER	5424	SMOOTH I	MEADOW N	WAY COLUM	BIA, MD	21044
ore	of He of He fitam		20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ F	i i	Ob. Place of Disponentery, cre	osition (Name of matory or other plac	ee)	Date 2	Oc. Location - City	or Town, State
<u>E</u>	Pages ment of I ant: If its ury or o		'4 □ Donation 5 □ Other (Specify)	- H	HEBREW YO	DUNG MEN	05,	/20/2005	WOODLAWN	, MD
Baltimore,	permit. Page Department Important: It any injury o		21. Signature of Funeral Service Licens	P (.111		2. Name and Addres		SOL LEVINS		
-	<u> </u>		Suew !!!	um						E, MD 21208
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ne cause on each line.	death. Do not en					Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Atherose		Caron	OVASC	war ?	) Iseas	C
	Examiner			Due to (or as a co	nsequence of):					
	1989	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):					
/	uted Id ansit	Examiner		c.						
oʻ	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Ex	resulting in death) Last	Due to (or as a co	nsequence of):					
8760,	cate be ex chysician the buria	dical	•	d						
9	eath certific attending p	w t	IF FEMALE:	20- 16						
Вох	attend attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of Month	delivery Day Year
o.	he de	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	ordeath St	Other (specify)				
Δ.	res that the de igned by the a be detached t		Part II. Other significant conditions co	ntributing to death but no	ot resulting in the o	inderlying cause giv	en in Part I.	23e. Did tob	acco use contribu	te to the cause of death?
Records,	quires n sigr ald be	d by						1 □ Ye	s 2 No 3	Probably 4-Unknown
CO	s been si should	Completed						24a. Was an		e autopsy findings available
Re	The lav te has age 2	шо						autopsy perform	ed2 deat	r to completion of cause of h? Yes 2□ No
Vital	iclan: Th certificate ector, pag	Ø	25. Was case referred to medical				26. Place of D	eath (Check only one		700 22110
f V	ys diis	To B	examiner? 1 ☐ Yes 2₩No	Hospital: 1   Inpatient	2 ER/Outpatie	nt 3 DOA Oth	er: 4 Wursing	Home 5 Reside	nce 6 Other (	Specify)
0 U	ng Ph Iter th neral		27. Manner of Death 1/√Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	of 28c. Injury Wor	y at k?	28d. Describe hor	w injury occurred	
Sio	andin eath. or: A the fu	catic	2 Accident investigation				Yes 2 □ No			
Division of	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, st Specify)	reet, factory, office		28t. Location (Str City or Town,		r Rural Route Number,
	pital ours a aral (		29a, Certifier 1 Certifying Phy	sician: To the best of m	y knowledge, dea	th annurad at the tin	no data and pla	una, and due to the on	usa/s) and manns	or as stated
	24 hc 24 hc Fun etely	Medical		iner: On the basis of exa						
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (N	fonth, Day, Year)
			1-12			D43	725		5/18/	05-
	0,		30. Name and address of person who c	ompleted cause of death	(Item 23a) (Type	Print)		T-1	-	MD 2122.
	1			MUOD 201.	-109 Ba	acle Rive	~ Nec	cle Rd	Balhin	ME
	Sta Regist		31. Date filed (Month, Day, Year)  MAY 2. 3 2005	32. Registrar's	Signature	w				Month, Day, Year)  VS  V()  V()  J()  J()

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.-Decedent's Name (First, Middle, Last) 2. Date of Death Month Yeer **Physician** JR. 3:28 PM 2005 1 hompson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HEALTHCA RE NIA SAINT AGINES BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 12 M 2□ F 60 Yrs. 212-42-7592 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 7 is marked other then "natural", or items 23e or 28a-f show treumatic event, the Medical Examinar must be notified at 1 Yes 2 No NIA Baltimore Completed by Funeral Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Marydell 21229 Rd. USA 372 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ges 1 and 2 should be filed within.
I of Health and Mental Hygiene.
If Item 27 Is marked other then "r.
or other treumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Plumbing Plumber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Rachel Cox William A. Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 372 Marydell Rd. Lillie Marcelle Thompson - Wife Balto. mo 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of Hu
Importent: If Iter
any injury or oth 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Arbutus Mem. Park 5-25-05 4 □ Donation 5 □ Other (Specify) 21. Signature of Juneral Service Licens.

22. Name and Address of Facility

23a. Party. En er, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

23a. Party. En er, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

23a. Party. En er, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

23a. Party. En er, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate use (Final disease or ondition resulting in death) PNEUMONIA ASPIRATION 7 DAYS Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit Due to (or as a consequence of): 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐ Unknown 5 Other (specify) Ö ۵ been signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ò 1 Yes 2 No 3 Probably 4 Noknown BRAINSTEM STROKE page 2 should Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? Yes 2X No 1 ☐ Yes 1 🗌 Yes Vital filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 2 of this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification; Division or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 P18606 MD 2005 MAY

State Registrar 31. Date filed (Month, Day, Year) MAY 2 3 2005

327 Registrar's Signature

fports

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AJJA1 ALVA, 900 CATON AVENUE BALTIMORE, MD

HOM PSON

			For State Registrar	State of Maryl	-	artment of F			jiene	5	171	94
	Physicia	an	Decedent's Name (First, Middle, Last)  IDA		TE	/EROVSKY		2. Date of Dea Month	th	Year	3. Time of 5:45	Death P M
	/Medic		4a. Facility Name (If not institution, give	street and number)	i E l	4b. City. Town, o	r Location of De		4c. County o		5:45	P
	Examin	er	MILFORD MANOR NUR			BALTII			BALTI			
	Funeral Director		5. Social Security Number 6. Sex 212–41–0550	7. Age (In 7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		Year)	9. Birthpl Coun	ace (State or try) UKRA	
			Usual Residence of Decedent					10/10/1	.920			
	arylan show	_	10a. State 10b. County		. City, Town or Li	ocation				10	0d. Inside City 1 □ Yes	
	tha Mi	Director	MD HOWARD  10e. Street and Number	CO	OLUMBIA	10f. Zip Code	_		log. Citizen of Wi	at Coun		X
	with With		7080 CRADLEROCK	WAY ADT #	117	21045			UKRAINE	iat oodii	.,.	
	death ms 2:	Funeral		12. Was Decedent Ever			ispanic Origin?	(Specify Yes or No- erto Rican, etc.)				
9	after or Ite	/ Fui	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give		1 Yes 2 No	Specify:	ento ritican, etc.)	Specify:	White, 6		
5-0036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show the Madical Exertinative codified at	d by	3 X Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:		dent's Usual Occup	ation		16b. Kind of Bus	iness/Ind	lustov	_
7	in 72 n "nat	plete	(Specify only highest grade	e completed)	(Give	kind of work done of DO NOT use retired	durina most of v	vorking	TOD. INITE OF DES	11633/1110	idatiy	
2121	ba filed within 72 hours after death with tha Marylar ital Hyglene. Id othar then "naturel; or liems 23e or 28e-f show of othar then "naturel; or liems at must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	HOME	MAKER			OMN HON	1E		
aryland	ba filed Ital Hygid od othar event, I	Be	17. Father's Name (First, Middle, Last)		1/	LEED		lame (First, Middle,	Maiden Sumame	)	LOTIC	
2	s 1 and 2 should by f Health and Menta item 27 is marked other traumatic ev	은	SOLOMON  19a, Informant's Name/Relationship (Ty	pe. Print)		LEER	MARIE and Number or	Rural Route Numbe	r, City or Town, S	tate, Zip	LOTIS	
≥	nd 2 state at trau		ALEXANDER TEVEROV	-		APRIL JO		COLUMBIA,				0
altimore,	es 1 a of Hea f item r othe		20a. Method of Disposition  1    Burial 2 □ Cremation 3 □ F	20	b. Place of Dispo cemetery, cre	osition (Name of matory or other place	ce)		20c. Location - C		wn, State	
Ĕ	Pages Iment of tant: If it jury or o		* 4 □ Donation 5 □ Other (Specify)	C			-				BIA, M	D
Bai	permit. Pages Department of Important: If it eny injury or once.		21. Unautre of Figure 1 Salvice Censee 22. Name and Address of Facility SOL LEVINSON & 8900 REISTERSTOWN ROAD - PIKES									208
	Physician		23a. Part1. Inter the disease, or compleshock, or heart failure. List only or immediate Cause (Final	ications that caused the ne dause on each line.	1	ter the mode of dyin	/	brun)	rest,	4	Approximate Interval Betw Onset and D	eath
	/Medical		disease or condition resulting in death)	Due to (or as a cor		03/12/1/1	1	Druch /		u	MIM	
P	Examiner	_	Sequentially list conditions,	Due to (or as a cor	sequence at):							
×	uted d ansit	Examiner	superitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
0	sate be executed obly sician and the burial-transit		resulting in death) Last	Due to (or as a cor	nsequence of):							
8760,	icate b physic the bu	dical		d		···						
Box 6	eath certific attending p I for use as I	√/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pr					23d. Date	of delive	ry	
о. В	The law requiras that the death certificate be executed to has basn signed by the attending physician and otge 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 2□ 4□Pregnant at time 9□Unknown		☐Ectopic pregnancy ☐ Other (specify)			Mont	h	Day Y	ear
σ.	that the de led by the a detached f		Part II. Other significant conditions cog	ntabuting to death but no	t resulting in the t	underlying cause giv	en in Part I.	23e. Did to	bacco use contrit	oute to th	e cause of de	eath?
rds	w requiras that s baan signed t should be det	d by		Merters	un			1 🗆 Y	es 2□No 3	Prob	ably 4 📶	nknown
Records,	law reas bas 2 sho	plet		xering				24a. Was a	sv l pr	or to con	osy findings a	vailable use of
		Completed						perfor 1 ☐ Yes		ath? Yes	2□ No	
Vita	sicien: certific	Be	25. Was case referred to medical examiner?	Hospital:	- T-CO-0	oth	or	Death (Check only or		10		
ō	y Phys er this eral di	n: To	1 Yes 2 No '	28a. Date of Injury (Month, Day Yea	2 ☐ ER/Outpatie	INT 3LL DOA	Nursing	g Home 5 Resid 28d. Describe h	ow injury occurre		′)	
ion	ttending death. stor: Afte / the fun	atio	1 Natural 5 Pending 2 Accident investigation	(MONIII, Day 198	ar) Injury		Yes 2 □ No					
Division of Vital	al or Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, st pecify)	reet, factory, office		28f. Location (S City or Tow	itreet and Number n, State)	or Rura.	l Route Numb	ber,
	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical C		sician: To the best of my ner: On the basis of exa and manner stated.								
	To the I	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed	(Month, I	Day, Year)	
}	,			pus		1	1 / 17	07	311	410	)	
	\		30. Name and address of person who of	Jet Tem	in	1838	Green	69 Tree	Pol		4208	9
	Sta Registi		31. Date filed (Month, Day, Year) MAY 2 3 2005	2. Registrar's S	Signature	de						

		-	State of Maryland / Department of Health and Molecular State of Maryland / Department of Health and Molecular Amend Item 17 per fh G843 5-24-05 tas Certificate of Death	ental Hygie	ne No.2005	17195
	Physicia	an		2. Date of Death	Day Year	3. Time of Death
	/Medic Examin	er	4a. Facility Name (If not institution, give street and number) Battimore Rehabilitation Extended Care Battimore	, tay	4c. County of Death	
	Funeral Director		246-22-0727   *** ** 80   ***.	8. Date of Birth (Month, Day, Ye MARCH 8,	9. Birth 1925	olace (State or Foreign ntry) NC
	yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			Od. Inside City Limits
	he Mai	Director	MD BALTIMORE EDGEMERE	100	Citizen of What Cou	1 X Yes 2 □ No
	with t		10e. Street and Number 2513 EUGENE AVENUE 10f. Zip Code 21219	iog.	USA	Tury r
	deeth	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sperify Cuban, Mexican, Puerto Forces)	cify Yes or No-	14. Race - Ameri	
980	hin 72 hours after deeth with the Maryland B. Madical Examiner must be rodified at	ρ Σ	1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1943–46	noan, etc.)	Specify: BLA	ACK
21215-0036	"natur	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)	ng 16b	o. Kind of Business/Ir	dustry
212	r th	omp	Elementary/Secondary (0-12) College (1-4or 5+)  8  College (1-4or 5+)  BUILDING MANAGEMENT SU	JPERV.	FORT HOWA	RD VA HOSP.
	be filed stal Hygli d other	Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name  CONCORD ATTEMATICAL STREET			
Maryland	should be not Mental n marked c	은	CONCORD ALEXANDER WEDDINGTON  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura)	JDE CRAWF		Code)
	od 2 lith a 27 le		STEVEN WEDDINGTON/SON 7603 ASHTON VALLEY WAY			
Baltimore,	00			ate 20c	. Location - City or T	own, State
Him	Pa ant:		`4 □Donation 5 □Other (Specify) ARBUTUS MEM. PARK 5-25		ALTIMORE,	
Bal	permit. Departr Importe any inji		ames 9. Morton 1701-31 LAURENS ST.	. BALTIM	ORE, MARY	LAND 21217
F			23a. Pant Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	r respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Cevebrovascular Accident  Dye to (or as a consequence of):			
b	Examiner		Sequentially list conditions, b. Hypertension			
	nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
o,	sate be executed oblysician and the burial-transit		that initiated events resulting in death) Last Due to (or as a consequence of):			10
8760,	physics the bu	dica	d			
O. Box 6	The taw requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of deliv Month	ery Day Year
ls, P.0	res that I signed by I be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I,	23e. Did tobac	co use contribute to t	
Records,	w require been si should	ieted		24a. Was an	24b. Were auto	psy findings available
l Re		Completed		autopsy performed 1 Yes 2	prior to co death? No 1 ☐ Yes	mpletion of cause of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital: 15 Program 25 FR/Outpatient 25 FR/Out			
of		n; To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2	ne 5 ∐ Residence 28d. Describe how i	e 6 □Other (Speci injury occurred	(y)
sion	Attending I r death. ector: After by the funer	catio	2 Accident investigation M 1 Yes 2 No			
Division	s after death	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28t. Location (Stree City or Town, S	it and Number or Run State)	al Houte Number,
	To the Hospitel or Atte within 24 hours after de To the Funerel Direct completely filled in by th	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
)	T Military Co. Oom	Σ	29b. Signature and title of certifier  Leonge C. Will M. M.D.  29c. License number 041365	29d.	Date signed (Month,	Day, Year)
	U"		29b. Signature and title of certifier  Leorge E. Wille M. D., D41365  30 Name and address of person who completed cause of death (Item 23a) (Type, Print)  Beorge E. Wicks M. M.D., 3900 Loch Raven Boul	levard, B	Sattimore	MD. 21218
	° Sta Registi		31. Date filed (Month, Day, Year) MAY 2 3 2005			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death Reg. No. U 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician Peggy Lee Wolfe 7:02 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FRANKLIN SQUARE HOSPITAL CENTER ROSEDALE BALTIMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2√□ F Director 68 Dec. 8,1936 Maryland 213**-**34**-**1882 Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Madical Exertine triggs be notified at 1 ☐ Yes 2XXXIII Director Maryland Baltimore Rosedale 10f. Zip Cede 10g. Citizen of What Country? 10e. Street and Number or items 23a 9722 Philadelphia Road 21237 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.
Is marked other than "naturel", or ite 1 □ Never Married 2 □ Married 1 Yes 2 X No Specify: δ 3√√Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ethel Mae Bayliss Harold Keerans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an permit. Pages 1 and 2 Department of Health ar Importent; if item 27 is any injury or other trac 9722 Philadelphia Road Rosedale, Maryland 21237 Mr. Richard Ruger (Companion) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gdns 5/23/2005 Middle River, MD 4 Donation 5 Other (Specify) Entombment. 21. Signiture of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MALIGNANT NON-SMALL CELL LUNG CANCER Pnysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/MedIcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? COPD EFFUSION 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 2 🕱 No 1 Tes within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🕱 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

State Registrar

29a Certifier

29b. Signature and title of certifier

Dr. GLENN 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)

2

R 960 F7

f<mark>试 Certifying Physician:</mark> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D56477

29d. Date signed (Month, Day, Year)

BALTIMORE

			For State	State of Marylan				d Mental Hygier	2005	17107
			Registrar		Cer	tificate of l	Death	Reg.	No.	11111
	Physici	an	1. Decedent's Name (First, Middle, Las		iF (0)	-011			Day Year	3. Time of Death
	/Medic		CARL IAL	1 110	1501	4b. City, Town, or	1	5 15	5 ØS 4c. County of Dea	6.00 H "
	Examin	er	4a. Facility Name (If not institution, give	ARILITATION E	TENU	HT CAPE	RAI	TIMORE		ultimore City
	Francis		5. Social Security Number 6. Se	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 I	Hrs. 8. Date of Birth		rthplace (State or Foreign country)
	Funeral Director			⊋M 2□F 85	Yrs.	Months Days	Hours N	Min. (Month, Day, Ye. Aug. 5.19		aryland
	D		Usual Residence of Decedent				-	11119.		-
	arylar show	-	10a. State 10b. County	10c. CI	ty, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	Ba-f	Director		Ltimore		10f. Zip Code	Dun	dalk	Citizen of What C	
	with the		10e. Street and Number			Tot. Zip Code	-1-			
	ns 23	Funeral	1225 Delbert Ave	enue 12. Was Decedent Ever in U	.s. 13. V	Was Decedent of H	212		Jnited St	
10	ther d	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1⊈ Yes 2 ☐ No				? (Specify Yes or No- uerto Rican, etc.)	Black, Whi	ite, etc.
93	al', o	þ	3√ Widowed 4 □ Divorced	If Yes, Give Year or Dates WWII		1 ☐ Yes 212 No	Specify:		Specify:	White
21215-0036	72 hours after deeth with the Maryland natural; or items 23a or 28a-f show ilsal Examinat must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation	16a. Deced	tent's Usual Occup kind of work done	ation during most of	working 16b	. Kind of Business	
21	within ene.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. l	DO NOT use retired	3)			
	e filed within at Hygiene. I other than vent, the Ma		17. Father's Name (First, Middle, Last)	2 Years	Traf	fic Manac		Name (First, Middle, Maid		Supplies
anc	I be fi	Be	Ignatius Wiecie	ah				ie Aniela Kı	,	
Maryland	d 2 should be filed within 72 hours after deeth with the Marylar it and Mantal Hyglene. It is marked other than "natural", or Items 23a or 28a-1 show traumatic event. It is Medical Examination in a political at	မှု	19a. Informant's Name/Relationship (7		19b. Mailir	ng Address (Street		r Rural Route Number, Cit		Zip Code)
$\mathbf{\Xi}$	and 2 sho ealth and n 27 is m		Mrs. Carol R. I			-		_		y, VA 20151
ē,	- I 0 =		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other place	ce)	Date 20c	. Location - City or	r Town, State
Baltimore,	20= 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	•	•	1	. 5/19/2005	Dunda11	k. Marvland
alti	그 문란를 .		21. Signature of Funeral Service Licen		22	. Name and Addre	ss of Facility			
m	Depa Impo any in		stephene	41 assey	79	da-Ruck i 922 Wise	Ave. I	Home of Dur Dundalk, Mar	vland 2	10.
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused the dea	Do not ent	er the mode of dyir	ng, such as car	diac or respiratory arrest,	<u> </u>	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. ADENO	CAK	CINO,	MA	LIVER		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	Water of the later	10-10-00 s			
	LXammer	<u></u>	Sequentially list conditions,	b. Due to for as a consec	wanea ofi-					
	ped Isit	nine	ri arry, leading to immediate cause. Enter Underlying Cause (Disease or injury		, comment of					
	sicien and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	quence of):					
760,	te be executed ysicien and te burial-transit	cail		d				- ·-		
9										
Box	death certifica e attending ph ed for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 Live birth 2 Fet		Ectopic pregnancy	/		23d. Date of de Month	elivery Day Year
	deal	sicia	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of of		Other (specify)			MOUTH	Day
P.0	that the de ed by the a detached	Physician/Med	9 Unknown  Part II. Other significant conditions of	adfribution to doub but not re-	culting in the u	ndorhina sausa su	on in Part I	23e Did tohace	co use contribute	to the cause of death?
S,	The law requires that the ate has been signed by thoage 2 should be detached	by	HYDEPTENS		salang in the a	noonying cause giv	on an anti-	1 ☐ Yes		Probably 4 □Unknown
Records,	w requ	Completed	AGRIM CU	BRICCATIO.	1/			24a. Was an	24h Word :	autopsy findings available
360	has has b	mpi	HIKING FIL	SKICCIJIIV.	<u> </u>			<ul> <li>autopsy performed</li> </ul>	prior to 1? death?	completion of cause of
a			OF Management to modical				OO Diseased	1 Yes 2	No 1 ☐ Ye	s 2-0 No
Vital		Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	] ER/Outpatier	nt 3 DOA Oth	or	Death (Check only one)  ng Home 5  Residence	e 6 ∏Other (Sn	ecifu)
of	Phys ir this aral di	To :	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	the state of the s		28d. Describe how i		oony
lon	nding Phi th. : After thi e funeral	tioi	1. ☑ Natural 5 ☐ Pending investigation		Injury		Yes 2 ☐ No			
Division	or Attendate death Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At Inju	nome, larm, sti	reet, lactory, office		281. Location (Stree City or Town, S	t and Number or F tate)	Rural Route Number,
	rs after sal Dii	Cer						N		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medical Exar	ysician: To the best of my kn niner: On the basis of examin	owledge, deat ation and/or in	h occurred at the til vestigation, in my o	me, date and p ppinion, death o	lace, and due to the caus occurred at the time, date	e(s) and manner a and place, and du	as stated. ue to the cause(s)
	thin 2 the mplet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens	se number	29d.	Date signed (Mor	nth, Day, Year)
	X X X 8	1	DSD 2 ×	Hast	1	00	166	18 00	-15	2005
1	1		30. Name and address of person who	completed cause of death (Ite	m 23a) (Tune	Print)	1			
(-	MIO		SHER A HASH	MI MD 39	so Le	CH RAV	EN BO	LYD BALTI	HOREL	10 21218
		ate	31. Date liled (Month, Day, Year)	32 Begistra & Sign	ature /	Sparle	,	LYD BALTI		
	Regist	rar	I MAT	A U FUUT ARABA	ALL IN	9				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Decedent's Name (First, Middle, Last) **Physician** Stacey L. Wimbish /Medical 4a. Facility Name (If not institution, give street and number) Examiner ST. AGNES HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthd 6. Sex **Funeral** 1 □ M 2 🛛 F 42 Director 214-88-6622 Usual Residence of Decedent with the Maryland 10c. City, Town or 10b. County 10a State Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hyglene. Intel it is a 27 is marked of wher then "neturel", or items 23e or 28a-1 show intelligent any or other traumatic event, it a Maries is a ring matter nutilities at my or other traumatic event, it is Maries is a ring matter nutilities at Anne Arundel Severn Direct 10e. Street and Number 244 Burns Crossing Road Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: þ 3 X Widowed 4 □ Divorced Completed

Elementary/Secondary (0-12)

Marcus Bell

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

' 4 ☐ Ponation 5 ☐ Other (Specify) 21. Sign ture of the eral Service Licensee

Dorothy Wright / Mother

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State

11

Be

15. Decedent's Education (Specify only highest grade completed)

BALTIMOR	ZE Ba	Baltimore City						
Months Days Hours M	in (Month Day Year	9. Birthplace (State or Foreign Country) 1962 Maryland						
Location		10d. Inside City Limits 1 ☐ Yes 2 ☑ No						
10f. Zip Code	10g. C	Citizen of What Country?						
3. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pt  1 Yes 2 No Specify:	(Specify Yes or No- lerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify:White						
ocedent's Usual Occupation ive kind of work done during most of e. DO NOT use retired)	working	Kind of Business/Industry						
	Foo Name (First, Middle, Maide Ly Brown	od Service en Sumame)						
ailing Address (Street and Number or	Rural Route Number, City	or Town, State, Zip Code)						

2. Date of Death

Month

3. Time of Death

2:15 PM

Year

2005

4c. County of Death

Physician /Medical Examiner

attending physician ar

signed by the a

has been

certificate

this

After

death.

within 24 hours after death To the Funeral Director:

filled in by

or Attending Physicien:

MINBIGH

Physician/Medical

þ

Completed

Be

2

Certification:

Medical

requires that the death certificate be executed

Box 68760

permit. Pages 1
Department of H
Importent: If ite
eny injury or ot
once.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last

10001 0 11		TZI CIAIII DIZIWAY S.F. GIEII
23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused the death. only one cause on each line.	Do not enter the mode of dying, such as cardiac or respiratory arrest,
Immediate Cause (Final disease or condition	LIVER	arrto 815
resulting in death)	Due to (or as a conseque	ence of):
Sequentially list conditions,	b. Due to (or as a conseque	suce of).

Deli

19b. M

20b. Place of Disposition (Name of cemetery, crematory or other place)

22. Name and Address of Facility

1669 Shannon-D Circle Severn MD 21144

Metro Crematory, Inc. May 23,2005 Baltimore, MD

Date

rkley-Ruddick Funeral Home, P.A. I Crain Highway S.E. Glen Burnie MD 21061

Certificate of Death

4b. City, Town, or Location of Death

Due to (or as a consequence of):

IF FEMALE

23b. Was decedent pregnant in the past 12 months? 9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death

College (1-4or 5+)

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Day Month

20c. Location - City or Town, State

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes

Approximate Interval Between Onset and Death

Year

25. Was case referred to medical examiner 1 ☐ Yes 2 XNo 27. Manner of Death

1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) investigation

28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

26. Place of Death (Check only one)

29b. Signature and title of certifier

29c. License number FIGH

29d Date signed (Month, Day, Year) MAY

Caton Ave. Bultimore 21229

MEDICAL RETIDEN, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Osei-Beamah 900 mmanue

State Registra

0

31. Date filed (Month, Day, Year) MAY 2 3 2005

5 Pending

6 Could not be determined

 Registrar's Signature Sparke

DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 5-5-2005 11:04a<sup>M</sup> ISIK ATIL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bethesda Montgomery Suburban Hospital 8. Date of Birth (Month, Day, Year) 12-27-1928 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min 1 M 2 XF Turkey Yrs. 218-96-2061 Director Usual Residence of Decedent 10d, Inside City Limits the Maryland 10a. State 10c. City, Town or Location or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Inportant: if tiem 27 is marked other than "natural", or items 23e or 28e-1 show important: if tiem 27 is marked other than "natural", or items 23e or 28e-1 show injury or other traumatic event, the Wedical Exercities must be notified at once. Yes 2□No Potomac Maryland Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20854 Turkey 10265 Oakland Dr. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes X ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Halit Adiviye Ugral Bayrak 70 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10265 Oakland Dr, Potomac, Maryland 20854 Pelin Kocman - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 5-12-05 Izmir, Turkey Family Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Universal II Mortuary Inc. 21. Signature of Funeral Service Licensee 411 Kennedy St, N.W., Wash, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be exacuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attendion about a new law and the control of the present Director. attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) by the a 9 Unknown 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 🕶 o 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 

24b. Were autopsy findings available prior to completion of cause of death? has le 2 2 **2**No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check on one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 1 patient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28b. Time of Certification: 1 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Executive Ph Terr Germantown mo 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar MAY 06 2005

		1	For State	State of M		epartment of H Certificate of I			iene	17200
			Registrar  1. Decedent's Name (First, Middle, Las	t)				2 Date of Death	h	3. Time of Death
	Physicia		William R. Adl	rins				Month 5	Day Year O5	1248 M
	/Medic		a. Facility Name (If not institution, give		), 1	4b. City, Town, or	Location of Death		4c. County of Death	١.
			Peninsula Regionale	Medical	Centa	L	3 Q l lsblly		NICAMI	
F	uneral		5. Social Security Number 6. So	9x 7. A ☑ M 2 ☐ F	ge (In yrs. last birth	Months   Davs	Hours Min.	8. Date of Birth (Month, Day,	Year) Con	nplace (State or Foreign untry)
D	irector	_	221-14-9009 Usuaf Residence of Decedent	20.	81 *	5.		May 25,	1923 Del	aware
and	Mo to	_ <u>_</u>	10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
Mary	F B	to	MD Wicon	nico	Delmar					1xx Yes 2 ☐ No
h the	r 28e	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What Co	untry?
th wit	23a c		508 E. East Stree	t		21875			U.S.A.	
r dea	er m	Funeral	11. Marital Status	12. Was Deceden Armed Forces	7	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36 s afte	, or i	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 [X] Yes 2 [ If Yes, Give ] Year or Dates	ebApr.	1 ☐ Yes 2 🛣 No	Specify:		Specify: V	<i>N</i> hite
Maryland 21215-0036	eal E	edt	15. Decedent's Eq	lucation	1942 16a. [	ecedent's Usual Occup	ation		16b. Kind of Business/	Industry
27 Sign	Medill in	Completed	(Specify only highest gra	de completed) College (1-40)	.54)	Give kind of work done ife. DO NOT use retired	d)			
2	er the	Com	12			Bookkeeper			Car Dealers	ship
	d oth	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nam		Maiden Sumame)	
Vald i	merke arke	2	Riley W. Adkins		105	Mailing Address (Street	Lena Ha		City or Town State 7	in Code)
Mar 12 sh	7 Is m		19a. Informant's Name/Relationship		_			Delmar,		
<b>e</b> 1 and	It of realth and wenter tryberse.  If item 27 is marked other than "neture", or items 23a or 28e-f show or other traumatic event, the Medical Ever it at most be notified at	1	Elizabeth L. Adk 20a, Method of Disposition	ins (Wi	20b. Place of I	08 E. East Disposition (Name of		Tagada.	20c. Location - City or	
Pages	t: If it		1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specification)		9	crematory or other play phens Cem.		1,2005	Delmar, De	·laware
Baltimore,	Department of Health a Important: If item 27 Is any Injury or other tra		21. Signature of Funeral Service Licer		טני טנפ	22. Name and Addre	ess of Facility	A		
Balt permit.	Important land	4	A. Crawle			Short Fun 13 E. Gro	eral Home ve St. I	elmar, I	DE 19940	
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caus one cause on each	ed the death. Do no	ot enter the mode of dying	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
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	Medical aminer		resulting in death)	Due to (or a	is a consequence o	r):		0	U	
EX	anniei	٠,	Sequentially list conditions,	b. Due to /or a	as a consequence o	n.				
pe	ısıt	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or t	a consequence o	,.				
axecul	al-trai	xar	that initiated events resulting in death) Last	Due to (or a	as a consequence o	f):				
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68 tifficat	ig phy as th	led	12 551111 5							
Box eath cert	attending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth	ne of pregnancy 2  Fetal death	3 Ectopic pregnanc	у		23d. Date of del Month	livery Day Year
O. E	the att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant 9☐ Unknown	at time of death	5 Other (specify)				·
Records, P.O.	ed by the detached		Part II. Other significant conditions	contributing to death	but not resulting in	the underlying cause gr	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
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Rec	page 2	dmo						autops perfor		completion of cause of
-	tificate tor, pa		25. Was case referred to medical				26. Place of Dea	th (Check only or		
	is cert direct	o Be	examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 Inpa	atient 20 ER/Out	patient 3 DOA Ot	her: 4 🗆 Nursing H	ome 5 Resid	ence 6 Other (Spe	icify)
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Division To the Hospitel or Attending	after death   Director: , d in by the f	Certification:	3 Suicide 6 Could not to determined	200. Flace 01	Injury - At home, far etc. (Specify)	m, street, factory, office		City or Tow	n, State)	Ji ai noute ivuilibei,
D je	erel C		29a. Certifier 1 Certifying P	hysician: To the be	st of my knowledge	, death occurred at the t	ime, date and place	, and due to the d	cause(s) and manner a	s stated.
8 Hos	within 24 hours of the Funeral completely filled	Medical	(Check only 2 Medical Exa	miner: On the basi and manner	s of examination and	Vor investigation, in my	opinion, death occu	rred at the time, o	date and place, and du	e to the cause(s)
o #	within Fo th compl	Me	29b. Signature and interof certifier			29c. Licer	ise number	-	29d. Date signed (Mon	th, Day, Year)
<b>)</b> [	X ~		> M	- MD			D54127		25/08/0	)5
1	18		30. Name and address of person who	. 0	- 1		- h	10.1.5	11011	
-	<b>\</b>		31. Date filed (Month, Day, Year)	32. <b>Pa</b>	istrar's Signature		shury	mo	21809	
	St Regist	ate trar	MAY 0 9	2005	eve &	Sperle				

		1	For State Registrar		Sta	te of M	<b>1</b> arylan		artment rtificate			and M	ental Hy	giene Reg. No. ; (		17000
	Physicia	an	1. Decedent's Name <i>(Fi</i> Giovanna	irst, Middle,		estro		Auri	cchio				2. Date of Dea Month May 5	Davi	Year	3. Time of Death 3:53 PM M
	/Medic Examin	_	Shady Gro					1		Town, or ckvi	Location o	of Death			unty of Death	У
	Funeral Director		5. Social Security Numb		. Sex 1 □ M 2		ige (In yrs. 41	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da May 2,	1964	9. Birth Cou Napo	place (State or Foreign ntry) Dli, Italy
	ath with the Maryland 23a or 28a-1 show			b. County Iontgo	mery			y, Town or Lo								10d. Inside City Limits 1 AYes 2 No
	with the	<u>a</u>	10e. Street and Number					\ /	10f. Zip		. 0				of What Cou	ntry?
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21215-0036	S 2	Completed		only highest	grade comp	oleted) llege (1-40	r 5+)	(Give	kind of wor DO NOT us nemake	rk done d se retired)	uring most	t of worki	ng		Home	
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	nd 2 sho alth and 27 is m		19a. Informant's Name Vitale A	,		•	and			,			a <i>l R</i> oute Numbe 04 Rock			
Baltimore,	Pages 1 and nent of Healint: If item 2 iny or other		20a. Method of Disposit  1 Burial 2 C  4 Donation 5X	tion remation 3	B □Remova	al from Stat	20b. F	Place of Disponentery, creametery, creametery	sition (Nan	ne of ther place	9)	[	-14-05	20c. Locati	on-City or T	own, State
Balti	permit. Pages Department of Important: If is any injury or once.		21. Signature of Funeral Service Lidensee  22. Name and Address of Facility Bergen Funeral Service 129 E. 7th Street New York, New York 10009  23a. Part 1. Ever the diseasa at amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrests.  Approximate													
8760,	Physician and busician and busician and physician and physician and steep the physician and physicia	dicai Examiner	Sequentially list condition resulting in death)  Sequentially list condition for any, leading to immediate. Enter Underlying Cause (Disease or injust that initiated events resulting in death) Last	ilure. List of al ions, diate ng ry	ab	Due to (or a	as a consequence as a c	uence of):	B	nofi	Sel Ly	Pin Mr.	Fine!	ron	^c	Interval Between Onset and Deputs Imper
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<u>a</u>	w requires that the body is the consistency of the constant of	by	Part II. Other significar	nt condition	s contributi	ing to death	but not res	ulting in the u	inderlying c	ause give	en in Part I			obacco use		the cause of death?
I Reco		Completed		_									24a. Was autop perfo 1 \( \text{Yes}	an 2 bsy med? 2 No	4b. Were aut prior to co death? 1 \( \sum \text{Yes} \)	opsy findings available ompletion of cause of
Vita	/sician: Th s certificete director, pag	To Be (	25. Was case referred examiner? 1 Yes 2 □ No	to medical	Hospita	al:	tient 🗽	ER/Outpatie	nt 3 DC	Othe			me 5 ☐ Resi		Other (Snec	fu)
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific compietely filled in by the funeral director,	Certification; T	27. Manner of Death  1 Natural 5	i Pending investiga Could no determin	ition	a. Date of Ir (Month, I	njury Day Year)	28b. Time of Injury	f 2	8c. Injury Work		No	28d. Describe	now injury or	curred	al Route Number,
	To the Hospitat or within 24 hours after To the Funerel Dir completely filled in	Medical Co	29a. Certifier (Check only one)	Certifying Madical E	xeminer: O	: To the be on the basis	of examina	owledge, dea ation and/or ir	h occurred evestigation	at the tim	ne, date an pinion, dea	id place, ith occur	and due to the red at the time,	cause(s) and date and pla	d manner as	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title	of certifier	ni	0	mel	1 Mh	290	License	number 3	26	7	29d. Date si	gned (Month	Day, Year)
-	5		30. Name and address William	,			f death (Iter	9901	Medi	cal	Cente	er Di	., Roci	kville	, MD 2	.0850
	Sta Regist		31. Date filed (Month, L	Day, Year)	2005	320 Regi	strar's Sign	ature Ap	de							

		•	For State Registrar	State of Ma	*	partment of ertificate of		d Mental Hyg	iene 2005	5 17203		
			1. Decedent's Name (First, Middle, Last	)				2. Date of Deat Month	th Day Year	3. Time of Death		
	Physici /Medic		Mark Stephen Al	perstein				May	8 2005	1:22 A M		
	Examin		4a. Facility Name (If not institution, give	street and number)		1	or Location of De	eath	4c. County of De			
			Montgomery Genera	l Hospital	-	Olney		ery				
	Funeral Director		373-04-0070	VM 20 E	(In yrs. last birthda	Months Davs		8. Date of Birth (Month, Day, 03/04/1				
	pur »		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits		
	/anyli	5	MD Montgome	rv	Silver	Spring				1 XYes 2 No		
	the A	ect	10e. Street and Number	<b>L</b> J	DILVEI	10f. Zip Code		1	0g. Citizen of What 0	Country?		
	with Sa or	<u>a</u>	14236 Long Green	Drive		2090	6		United States			
	ns 2%	Funeral Director	11. Marital Status	12. Was Decedent B	Ever in U.S. 1	3. Was Decedent of	Hispanic Origin?	? (Specify Yes or No- uerto Rican, etc.)				
(0	riter	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔯 N				uerto Rican, etc.)	Black, Wh			
8	el', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: Wh	116		
21215-0036	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show disal Examinat must be notified at	Completed	15. Decedent's Ede (Specify only highest grad	ication le completed)	16a. De	cedent's Usual Occu ive kind of work done e. DO NOT use retir	pation a during most of	working	16b. Kind of Busines	s/Industry		
21	Me We	gu	Elementary/Secondary (0-12)	College (1-4or 5	+)		ed)		Recreation	n Equipment		
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and	be fi	Be	17. Father's Name (First, Middle, Last) Hotsy Alperstein					•	iddle, Maiden Sumame)			
ž	12 should be fi h and Mental H 7 Is marked otl reumatic even	٦	Hotsy Alperstein  Miriam Baker  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State									
Maryland	d 2 sl th and 7 ls r treur		Therese Guilderso					ive Silver				
ė,	1 an Heal tem 2		20a. Method of Disposition			sposition (Name of crematory or other pl			20c. Location - City of			
ō	ages fr: # if		1 Burial 2 Cremation 3 1		Judean	crematory or other pi Memorial	Gdns 05	/11/2005	Olney, MD			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-f show among injury or other treumatic event, the Medical Examinational be notified at once.		21. Signature of Funer I S Price Licens	-	1	22. Name and Add	ress of Facility		_			
Ba	Dep Imp		toma (	Sent	-	Hines-Rin	aldi Fu	neral Home	Inc Iver Spri	ng, MD 20904		
		$\Box$	234. Part1. Enter the disease, or comp	lications that caused	the death. Do not	enter the mode of dy	ving, such as car	diac or respiratory arr	est,	Approximate Interval Between		
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	/Medical		disease or condition resulting in death)	a. Due to (or as	a consequence of):	THE CELL	MOVA	sugar c	11 tome	minutes		
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68760,	ate b hysic the bi	licai		d								
<u>6</u>	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the buriat-transit	Med	IF FEMALE:	20- 16								
Вох	ath co	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	2 🗌 Fetal death	3 Ectopic pregnan	су		23d. Date of d Month	elivery Day Year		
	that the de led by the a detached f	Physician/M	1 Yes 2 No	4□Pregnant at 9□Unknown	time of death	5 ☐ Other (specify)						
P.0	es that ti gned by be detac		Part It. Other significant conditions co	ntributing to death bu	ut not resulting in th	e underlying cause g	iven in Part I.	23e. Did tol	bacco use contribute	to the cause of death?		
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Division	l or Attending after death. Director; After in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be determined	280. Place of Inju	ury - At home, farm	, street, factory, office	0	28f. Location (Si City or Town	treet and Number or i	Rural Route Number,		
ā	s after of Direct	Certification:	4 _ Homelde	building, etc	. (Specify)			Shy di You	r, biato)			
)	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical (	(Check only 2 Medical Exam	iner: On the basis of	examination and/o	eath occurred at the r investigation, in my	time, date and p opinion, death o	place, and due to the concourred at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)		
	o the ilhin 2 o the imple	Med	one) 29b. Signature and title of certifier	and manner sta		29c. Lice	nse number	2	9d. Date signed (Mo	nth, Day, Year)		
			Miller Colina	1. 1.0	Vaes	Dor	28420	9 1	May &	2005		
•	3		30 Name and address of person who	completed cause of d	eath (Item 23a) (Tu	pe. Print) Dh	Illi E.	Wicholson.	MD 0,0			
			Montgomery Rene	ral Hosoi	tal 1x	101 Prin	ce Phil	llip Drive	Olney	Maryland		
	Sta	ate	29b. Signature and title of certifier  August Culd  30. Name and address of person who of  Montgomery Gune  31. Date filed (Month, Day, Year)  MAY 10 20	32 Registra	ar's Signature	Cook 8	V 10.1			20832		
	Regist		MAY 10 20	105 Kineus	J. J. P.	A STATE OF THE PARTY OF THE PAR						

Usual Readerisons of Deceders   10c. City, Town or Location   10c. City, Town or Location   10c. Zip Code   20746	6:34 P M eath corge's Birthplace (State or Foreign Country) Hampshire  10d. Inside City Limits 1 Yes 2/12/No Country?  merican Indian, thite, etc. White
Funeral Director  Funeral Dire	6:34 P M eath corge's Birthplace (State or Foreign Country) Hampshire  10d. Inside City Limits 1 Yes 2/12/No Country?  merican Indian, thite, etc. White
Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Security Number  Funeral Director  Funeral Director  Funeral Security Number  Funeral Director  Funeral Director  Funeral Security Number  Funeral Director  Funeral Security Number  Funeral Director  Funeral Business of Decedent  Funeral Director  Funeral Business of Decedent  Funeral Director  Funeral Business of Decedent  Funeral Director  Funeral Business of Decedent  Funeral Business of Decedent  Funeral Business of Decedent  Funeral Business of Decedent  Funeral Business of Funeral Busi	eorge's Birthplace (State or Foreign Country) Hampshire  10d. Inside City Limits 1 Yes 252No  Country?  merican Indian, thite, etc. White
S. Social Security Number   S. Social Security Number   O3-12-0206   1 m 2 lx   F   91   vrs.   1 lunder 1 year   1 lunder 24 Hrs.   8. Date of Birth   Month, Day, Year   91   Month, Day, Year   92   Month, Day, Year   93   Month, Day, Year   94   Month, Day, Year   9	Birthplace (State or Foreign Country) Hampshire  10d. Inside City Limits 1 Tyes 200 No  Country?  merican Indian, thite, etc.  White
Director    Director	Hampshire  10d. Inside City Limits 1 Tyes 2/12/No  Country?  merican Indian, thite, etc.  White
Physician   Medical Examiner   Sequentially list conditions, if any, leading to immediate   Due to (or as a consequence of):    Cancer   C	1 ☐ Yes 2, 1 No  Country?  merican Indian, thite, etc.  White
Physician   Medical Examiner   Sequentially list conditions, if any, leading to immediate   Due to (or as a consequence of):    Cancer   C	Country? merican Indian, thite, etc. White
Physician   Medical Examiner   Sequentially list conditions, if any, leading to immediate   Due to (or as a consequence of):    Cancer   C	merican Indian, thite, etc. White
Physician   Medical Examiner   Sequentially list conditions, if any, leading to immediate   Due to (or as a consequence of):    Cancer   C	white etc. White
Physician   Medical Examiner   Sequentially list conditions, if any, leading to immediate   Due to (or as a consequence of):    Cancer   C	white etc. White
Physician   Medical Examiner   Sequentially list conditions, if any, leading to immediate   Due to (or as a consequence of):    Cancer   C	
Physician   Medical Examiner   Sequentially list conditions, if any, leading to immediate   Due to (or as a consequence of):    Cancer   C	ss/Industry
Physician   Medical Examiner   Sequentially list conditions, if any, leading to immediate   Due to (or as a consequence of):    Cancer   C	
Physician   Medical Examiner   Sequentially list conditions, if any, leading to immediate   Due to (or as a consequence of):    Cancer   C	
Physician   Medical Examiner   Sequentially list conditions, if any, leading to immediate   Due to (or as a consequence of):    Cancer   C	3
Physician   Medical Examiner   Sequentially list conditions, if any, leading to immediate   Due to (or as a consequence of):    Cancer   C	
Physician   Medical Examiner   Sequentially list conditions, if any, leading to immediate   Due to (or as a consequence of):    Cancer   C	a, Zip Code)
Physician   Medical Examiner   Sequentially list conditions, if any, leading to immediate   Due to (or as a consequence of):    Cancer   C	
Physician   Medical Examiner   Sequentially list conditions, if any, leading to immediate   Due to (or as a consequence of):    Cancer   C	or Town, State
Physician   Medical Examiner   Sequentially list conditions, if any, leading to immediate   Due to (or as a consequence of):    Cancer   C	Virginia
Physician   Medical Examiner   Sequentially list conditions, if any, leading to immediate   Due to (or as a consequence of):  23a. Pair Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	Home P.A.
Physician   Medical Examiner	Approximate Interval Between
Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):	Onset and Death
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
Due to (or as a consequence of):    Secure   Due to (or as a consequence of):	
Due to (or as a consequence of):    Consider that inflated events resulting in death) Last   Due to (or as a consequence of):	
FFEMALE:   23d. Date of motivation of pregnancy   23d.	
FFEMALE:   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   1   Yes   2   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   1   Yes   2   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   1   Yes   2   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   1   Yes   2   23c. Did tobacco use contributions of the underlying cause given in Part I.   23e. Did tobacco use contributions of the underlying cause given in Part I.   23c. Did tobacco use contributions of the underlying cause given in Part I.   23c. Did tobacco use contributions of the underlying cause given in Part I.   23c. Did tobacco use contributions of the underlying cause given in Part I.   23c. Did tobacco use contributions of the underlying cause given in Part I.   23c. Did tobacco use contributions of the underlying cause given in Part I.   23c. Did tobacco use contributions of the underlying cause given in Part I.   23c. Did tobacco use contributions of the underlying cause given in Part I.   23c. Did tobacco use contributions of the underlying cause given in Part I.   23c. Did tobacco use contributions of the underlying cause given in Part I.   23c. Did tobacco use contributions of the underlying cause given in Part I.   23c. Did tobacco use contributions of the underlying cause given in Part I.   23c. Did tobacco use contributions of the underlying cause given in Part I.   23c. Did tobacco use contributions of the underlying cause given in Part I.   23c. Did tobacco use contributions of the underlying cause given in Part I.   23c. Did tobacco use contributions of the underlying cause given in Part I.   23c. Did tobacco use contributions of the underlying cause given in Part I.   23c. Did tobacco use contributions of the underlying cause given in Part I.   23c. Did tobacco use contributions of the underlying cause given in Part I.   23c.	
23d. Date or Month  23b. Was decedent pregnant in the past 12 months? 1	
The state of the	delivery Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  1	Day rear
24a. Was an autopsy performed? deat class referred to medical examiner?  25. Was case referred to medical examiner?  1   Yes   2   20   0   3    24b. Wer autopsy performed? deat class referred to medical examiner?  25. Was case referred to medical examiner?  1   Yes   2   20   0   3    24a. Was an autopsy performed? class referred to medical examiner?  1   Yes   2   20   0   3    24b. Wer autopsy performed? class referred to medical examiner?  1   Yes   2   20   0   3    25. Was case referred to medical examiner?  1   Yes   2   20   0   3    25. Was case referred to medical examiner?  1   Yes   2   20   0   0    26. Place of Death (Check only one)  Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA   Cher. 4   Nursing Home   5   2   4	
24a. Was an autopsy performed?   24b. Wer autopsy performed?   1   Yes 2 🖾 No	to the cause of death?
autopsy prior deal per of the per	to the cause of death?  Probably 4 □Unknown
25. Was case referred to medical examiner?  1	Probably 4 Unknown autopsy findings available
Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Cther: 4 Nursing Home 5 to the sidence 6 Other /.	Probably 4 Unknown autopsy findings available to completion of cause of
200 Date of Davids	Probably 4 Unknown autopsy findings available to completion of cause of
27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28c. Injury a	Probably 4 ☐Unknown autopsy findings available to completion of cause of? es 2☐ No
2 Accident investigation M 1 Yes 2 No  2 Accident investigation M 1 Yes 2 No  3 Suicide 6 Could not be determined determined  28e. Place of Injury - At home, farm, street, factory, office  28f. Location (Street and Number of N	Probably 4 ☐Unknown autopsy findings available to completion of cause of? es 2☐ No
28a. Date of Injury 28b. Time of 28c. Injury at Work?  1 Natural 1 Natural 2 Accident investigation 3 Suicide 4 Homicide 4 Homicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number of City or Town, State)  28a. Date of Injury 28b. Time of Injury at Work?  1 Note: Work?  28b. Time of Injury at Work?  28c. Injury at Work?  28c. Injury at Work?  28d. Describe how injury occurred	Probably 4 Unknown autopsy findings available to completion of cause of ? es 2 No
29a. Certifier 29a. Certifier (Check only 19 Medical Examiner: On the basis of examination and/or investigation, in my oninion, death occurred at the time, date and place, and due to the cause(s) and manner of the basis of examination and/or investigation, in my oninion, death occurred at the time, date and place, and	Probably 4 Unknown autopsy findings available to completion of cause of ? es 2 No
2   Accident   3   Suicide   4   Homicide   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number of City or Town, State)   29a. Certifier (Check only one)   29a. Certifier   29a. Cert	Probably 4 Unknown autopsy findings available to completion of cause of res 2 No pecify)  Rural Route Number,
	Probably 4 Unknown autopsy findings available to completion of cause of res 2 In No pecify)  Rural Route Number, as stated. If you have to the cause(s)
	Probably 4 Unknown autopsy findings available to completion of cause of res 2 In No pecify)  Rural Route Number, as stated. If you have to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nelson Benjers MD 90735	Probably 4 Unknown autopsy findings available to completion of cause of res 2 In No pecify)  Rural Route Number, as stated. If you have to the cause(s)
State 31. Date filed (Month, Day, Year) 2. Registrar's Signature	Probably 4 Unknown autopsy findings available to completion of cause of res 2 In No pecify)  Rural Route Number, as stated. If you have to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nelson Benjers MD  9131 Place Through Load CLinton, mD  31. Date filed (Month, Day, Year)  MAY 1:0 2005  P. Registrar's Signature  MAY 1:0 2005	Probably 4 Unknown autopsy findings available to completion of cause of res 2 In No pecify)  Rural Route Number, as stated. If you have to the cause(s)

			1- For State of Maryland / Department of Maryl	artment of Health and M rtificate of Death		ene g. No. 005	17205				
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death				
	Physicia /Medic	al	James Anthony Burgess Sr		May 8,	2005	6:00 A M				
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death					
			Southern Maryland Hospital	Clinton  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Prince Geo	rges lace (State or Foreign				
П	Funeral		5. Social Security Number 6. Sex 152 M 2 F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 87 Yrs.	Months Days Hours Min.	(Month, Day, Sept 5,	Year) 1917 New Y	tru)				
	Director		Usual Residence of Decedent		Dort of						
	yland		10a. State 10b. County 10c. City, Town or Lo	ocation		1	Od. Inside City Limits				
	Ba-fa	ctor		ver1y			1  Yes 2 No				
	or 26	Dire	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Coun	try?				
	s 23a	ral	1614 Marblewood Avenue  11. Marital Status 12. Was Decedent Ever in U.S. 13.	20785	acifu Ves or No-	U.S.A	an Indian				
36	be filed within 72 hours after death with the Maryland ntal Hygiene.  od other than "natural", or Items 23a or 28a-f ahow avant, the Medical Evanti ver mat be notified at a and.	by Funeral Director	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White, Specify: Afri Amer	etc. can				
21215-0036	tural	edt	15 Decedent's Education 16a, Dece	dent's Usual Occupation	. 1	6b. Kind of 8usiness/Inc					
212	nin 72  na "na Medii	Completed	(Specify only highest grade completed) (Give	kind of work done during most of work DO NOT use retired)	ing						
21	giene giene er tha	E O	12	Supervisor		Governmen	it				
nd	be filed tal Hygie d other avant, I	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, M btainabl						
yla	2 should be and Mental is marked (aumatic av	2	Unobtainable	ng Address (Street and Number or Run			Code				
Maryland	s 1 and 2 should f Health and Mer itam 27 is marke othar traumatic			5 Prince Place Upp							
d)	es 1 and 2 of Health a fitam 27 is r othar trai					Oc. Location - City or To					
no	ages ant of nt: If il		1 ☐ Burial 2 ত Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)  Fort Lin	coln Crematory 5	/12/05 H	Brentwood, N	MD OIL				
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or ot		21. Signature of Funeral Service Licensee 2	2. Name and Address of FacilityFor 3401 Bladensburg R							
			23a. Part1. Enter the disease, or complications that caused the death. Do not en	ter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between				
	Pnysician :		shock, or heart failure. List only one cause on each line.								
	/Medical		resulting in death)  Due to (or as a consequence of):	`							
ı	Examiner		Sequentially list conditions, b. HIPERTEN	SION							
	be sit	iner	cause. Enter Underlying Cause (Disease or injury								
	ecute and I-tran	Examiner	that initiated events resulting in death) Last  C								
760,	ate be executed hysician and the burial-transit	icalE	d								
687	ificate g phys		0.								
O. Box	that the death certificate be executed ted by the attending physician and detached for use as the burial-transit	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year				
<u>α</u>	uires that t signed by ild be deta	by		underlying cause given in Part I.		acco use contribute to the	u				
Records,	The law requires that the ate has been signed by thoage 2 should be detache	Completed			24a. Was ar autops perform 1 Yes 2	y prior to co	psy findings available mpletion of cause of 2 No				
Vital		BeC	25. Was case referred to medical examiner?		th (Check only one	9)					
of V	Physician: this certificanal director,	To	1 ☐ Yes 2 No Hospital 1 Inpatient 2 ☐ ER/Outpatie			nce 6 Other (Specif	y)				
			27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred					
Sio	Attanding or death.  actor: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s		28f. Location (Str	reet and Number or Rura	al Route Number,				
Division	i ji ji	Certification:	4 Homicide determined building, etc. (Specify)	root, radory, onloo	City or Town						
	Hospital 4 hours Funaral (ely filled	edical C		th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the ca red at the time, da	tuse(s) and manner as s ate and place, and due to	tated. o the cause(s)				
	within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	25	9d. Date signed (Month,	Day, Year)				
			Joseph John March	D48158	1	MY 8, 20	05				
R	(8)		30. Name and address of person who completed cause of death (Item 23a) (Type SISOM OSIA, GIFZ OXON HILL		XON HII	L MD 207	45				
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  MAY 1 0 2005	ريو							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 3:00 a May 3, 2005 ophia /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Potomac Montgomery manorcare plomac Birthplace (State or Foreign Country) If Under 1 Year II Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 1 F 577 01 839 Usual Residence of Deceden 7018 91 Yrs. June 24, 1913 Washington DC Director 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rthan "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Potoma Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 0854 U.S.A. by Funerai death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Never Married 2 ☐ Married 1 Yes 2XXNo White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CPA Office Secretary permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: If tiem 27 is marked other til any injury or other traumatic event, in once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles M. Birckhead Sophia Kolb 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Doris Blazek-White/ POA 1201 Pennsylvania Avenue NW WDC 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State May 10, 2005 Suitland, MD Cedar Hill 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, 21. Signature of Funeral Pervice Licensee 5130 Wisconsin Avenue NW WDC 20016 23a. Part1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonia **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ol): Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deeth? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Cardiovascular Accident Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No Hypertension 24a. Was an med? 2 X No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check on one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 1 ☐ Yes \_ 2 🔀 No 3 DOA Medical Certification: To this 27. Manner of Death 1 XNatural 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) 28b. Time of After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident filled in by the within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 | Homicide tion can be stated as the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier May 3, 2005 D0054566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogavilli, M.D. 1220 A East Joppa Rd. Towson, MD . Registrar's Signature 31. Date liled (Month, Day, Year) State MAY 06 2005 Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State
Registrar\_AMEND#4as26perMD5/6/05, BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2005 Richard L. Brinkley May 2, 11:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital -Hospice Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Dec. 9, 6. Sex Birthplace (State or Foreign Country) **Funeral** <sup>Year)</sup> 1926 1X7M 2□ F 78 196-12-5179 Dec. Director Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Hem 27 is marked other then "naturel", or Hems 23e or 28a-f show 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other then "naturel", or items 23e or 28a-1 show giber treumatic event, it is Medical Examinar must be notified at 10d. Inside City Limits Director Yes 2 No Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2224 Richland Street 20910 United States Completed by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 □ X/es 2 □ No 1947 −
If Yes, Give
Year or Dates: 1948 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Computer Analyst U.S. Government Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Everett Brinkley Blanche L. Green 19a. Informant's Name/Relationship (Type, Frint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Brinkley (wife) 2224 Richland St. Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page
Department of
Importent: If
eny injury or
once. \* 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 5/5/05 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service homa 7400 Georgia Ave. N.W., Wash. D.C. 20012 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause appeach line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician End Stage Renal Disease disease or condition months /Medical resulting in death) Due to (or as a consequence of): **Examiner** Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last years Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): physician Box 68760 Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by Hypertension 3 ☐ Probably 【☐Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an funeral director, page 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospice Certification: To 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation death 2 Accident after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Hospitel 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and Tile of certifier D-32332May 3, 2005 5+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh K. Gupta, M.D. 9801 Georgia Ave. Suite 2-20, Silver Spring, MD 20902 . Registrar's Signature 31. Date filed (Month, Day, Year) State 0 6 2005 Registrar

Diane M. Buck 05-3 AKG

100	)		1 - For State Registrar	State of Marylan		artment of			Reg. No.	5   7208
	Physici /Medic Examir	cal	Diane Margaret     Asserting the state of the state	Buck street and number)		4b. City, Town	n, or Location of De Washing	2. Date of De Month May 4,	Day You 2005	3:20 P M Death e George's
	Funeral Director		5. Social Security Number 6. Sec 219-72-6369		last birthday) Yrs.	If Under 1 Ye Months Da	ear If Under 24 H			Birthplace (State or Foreign County) Washington
	ne Maryland 8a-f show	ector	Usual Residence of Decedent  10a. State 10b. County  Maryland Charl		y, Town or Lo	Road			-	10d. Inside City Limits 1 ☐ Yes 🏖 No
	th with the 23a or 2	al Dire	10e. Street and Number 2612 Dakota Str	reet		10f. Zip Cod	<sup>⊪</sup> 20616		10g. Citizen of Wha	
920	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Examinat roust be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 【★No If Yes, Give Year or Dates:		Was Decedent If Yes, specify O		(Specify Yes or Note to Rican, etc.)		American Indian, White, etc. White
1215-0036	filed within 72 ho Hygiene. Ither than "natur ant, the Wedical	Completed	15. Decedent's Edu (Specify only highest grad	cation le <i>completed)</i> College (1-4or 5+)	(Give	DO NOT use re	ne during most of tired)	working	16b. Kind of Busin	an School
land 21	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Importament of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinational be mailified at once.	To Be Co	12 17. Father's Name (First, Middle, Last) Edward Fa	aycheck	Send	ool Te	18. Mother's I	Name (First, Middle therine	, Maiden Surname)	Lewis
Maryland		-	19a. Informant's Name/Relationship (Ty	грө, Print) Husband					per, City or Town, Sta	
Baltimore,	Pages 1 ar nent of Hea int: If item 3 iry or other		20a. Method of Disposition  1	20b. F	Place of Dispo cemetery, crei	esition (Name or matory or other	-	Date 0 - 2005	20c. Location - Cit	
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service	M00668	4	270 Ha	wthorne	al Home	ndian He	ad, Md.2064(
	Physician /Medical Examiner	ər	23a. Part1. Enter the disease, or compishock, or beart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Pulmay 7	uence of):	bu embe	dying, such as card	ale ctr	Ryltj	Approximate Interval Between Onset and Death
8760,	certificate be executed rding physician and ise as the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, Isaumy to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a conseq						
O. Box 6	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as!	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Dunknown	23c. If yes, outcome of pregna 1	il death 3[	⊒Ectopic pregna ] Other (specify			23d. Date o Month	*
rds, P.	w requires that been signed t should be det	by	Part II. Other significant conditions co.	ntributing to death but not res	ulting in the u	nderlying cause	given in Part I.			ite to the cause of death?
Il Records,		Completed						24a. Was auto perfi 1/10 Yes	psy prio	re autopsy findings available r to completion of cause of th? Yes 2 \(\sumbed{\subset}\) No
of Vital	Physician: The this certificate ral director, pag	To Be	1 21 105 2 100		ER/Outpatier	IL SELDON	Other: 4 Nursin	7	idence 6 Other	(Specify)
Division o	Attending r death. ector: After	Certification:	27. Manner of Death  1 Natural 5 Pending investigation  2 Accident investigation  4 Suicide 6 Could not be determined	28a. Date of Injury (M. nth, Day Year)  3  28e. Place of Injury - At h. building, etc. (Specif	28b. Time of Injury  Low Kacome, farm, stroy)	M	njury at Work? 1 🗀 Yes 2 🗓 No ice	Subj	how injury occurred  If full a  (Street and Number own, State) 2.6 (3)	or Rural Route Number
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in the formulation of th	edical		sician: To the best of my kno ner: On the basis of examina and marmer stated.						
	To the within To the comp	W	29b. Signature and title of certifier	el. Kor	رب	29c. Lic OCM	ense number E		May 7, 2	
(	DB 16		30. Name and address of person who con THE ODOM M. (4)	rlar		•	Penn Str	eet Bal	timore, Ma	aryland 21201
	Sta	ate	NANV 1 0 7	32. Resistrar's Signa	J. 1	1000				

			_ State	tate of Maryland /		rtment of H			CHILL	17209		
_			Registrar  1. Decedent's Name (First, Middle, Last)		Cer	uncate of L		2. Date of Death	g. No.	1 / C. U.J		
	Physicia	an						Month	Day 2005	3. Time of Death		
	/Medic		Lucille N. Bartlett  4a. Facility Name (If not institution, give stree	et and number)		4b City Town or	Location of Death	May	4c. County of Dea			
	Examin	er	Harford Memorial Ho			Harve De			Harkord			
	Funeral		5. Social Security Number 6. Sex	7. Age (In vrs. last I	birthday)	If Under 1 Year		8. Date of Birth (Month, Day,		rthplace (State or Foreign		
	Director		195-14-4002 1□M	2CXF 92	Yrs.	Months Days	Hours Min.	January	10,1913	VA		
	pu .	-	Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wm or Lo	nation				10d. Inside City Limits		
	sho	ö				Cation				1 Yes 2V No		
	15e A	Funeral Director	PA Chester  10e. Street and Number	Oxfo	ord	10f. Zip Code		10	g. Citizen of What C			
	with with		130 Graves Road			19363			USA	ountry :		
	death	era	11. Marital Status 12.	Was Decedent Ever in U.S.	13. V		spanic Origin? (Spe n, Mexican, Puerto F		14. Race - Am	erican Indian,		
9	after or Ite	교	1 Never Married 2 Married	Armed Forces? I ☐ Yes 2 🔼 No		_		Rican, etc.)	Black, Whi			
8	rel', c	d by	3 X Widowed 4 □ Divorced	f Yes, Give Year or Dates:		Yes 21X No	Specify:		Specify: W	hite		
2	filed within 72 hours after death with the Maryland Hygiene. Hygiene sthen "neturely, or Items 23a or 28e-f show ent, the Medical Examinar must be indifficed at	Completed	15. Decedent's Education (Specify only highest grade co	n 16 mpleted)	(Give	lent's Usual Occupa kind of work done o	luring most of workin	ıg 1	6b. Kind of Business	s/Industry		
121	within then	du	Elementary/Secondary (0-12)	College (1-4or 5+)		00 NOT use retired, 1emaker	)		Own Home			
2 2	Hygie Hygie ther ant,	ပိ	17. Father's Name (First, Middle, Last)		11011	lemaket	18. Mother's Name					
an	ould be Mental arked o	To Be	John Friel Comer,	Sh				2 Loflin	,			
Maryland 21215-0036	Shoul nd Me mark	Ĕ	19a. Informant's Name/Relationship (Type,		9b. Mailin	g Address (Street a			City or Town, State,	Zip Code)		
Š	nd 2 alth a 27 ls r freu		Donald Comer/neph	2w 1	130 0	raves Rd	., Oxford	PA 19	363			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In Interface 11 is marked other then "neturely, or Nerms 23a or 28e-f show any injury or other treumatic event, the Medical Examinat must be inclined at once.		20a. Method of Disposition	20b. Place		sition (Name of natory or other place			0c. Location - City o	r Town, State		
Ĕ	Page nut: If iry or		1 ☐Xurial 2 ☐ Cremation 3 ☐ Remo `4 ☐ Donation 5 ☐ Other (Specify)	Wal Holli State		meteru	ı	2005	Oxford.	PA		
a	permit. Departm Importe any inju		21. Signature of Funeral Service Licensee	P 13				Foard	Funeral H	ome . P.A.		
<u> </u>	825 2 3		Kich and L.	foodie	11	1 S. Que	en Street,	, Rising	Sun, MD	21911		
Е			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one c	ons that caused the death. Dause on each line.	o not ent	er the mode of dying	g, such as cardiac or	respiratory arres	st,	Approximate Interval Between		
	nysician		Immediate Cause (Final disease or condition	CVA						Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or as a consequence SCIFIC SC	ce of):	4						
	LXammer	_	Sequentially list conditions, if any, leading to immediate	Due to or as a consequence		<u> </u>						
2	nsit	nine	cause. Enter Underlying Cause (Disease or injury	Due to for as a consequenc	e or):							
F.	xecu and al-trai	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequence	ce of):							
8760,	death certificate be executed to attending physician and of or use as the burial-transit	cai										
89	tificati ig phy as the	ed										
ŏ	leath certific attending p	Physician/M	23b. was decedent pregnant	If yes, outcome of pregnancy 1□Live birth 2□Fetal dea	ath 3.□	Ectopic pregnancy			23d. Date of de			
B.	ne deat the att hed fo	sicie	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of death 9☐ Unknown		Other (specify)			Month	Day Year		
P.O.	that the de ed by the detached	Phy	9 ☐ OUKHOWU					1				
Ś	uires tha signed I	by	Part II. Other significant conditions contrib	uting to death but not resulting	g in the ur	iderlying cause give	en in Part I.			to the cause of death?		
oro or	w requir been si should	eted						1 🗆 Yes		TODADIY 4 GOTIKTOWN		
Records,	8 S C	Completed						24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of		
B	n: Th icate r. pag							1 ☐ Yes 2	No 1 ☐ Ye			
Division of Vital	Physiclen: r this certifica ral director, I	o Be	25. Was case referred to medical examiner?	ital:		Othe	26. Place of Death					
o	Phys r this ral di	H-	1 Yes 2 No	8a. Date of Injury 28b	Outpatien  o. Time of	t 3□ DOA 28c. Injury Work	4   Nursing Hon	ne 5∐ Resider 8d. Describe hov	nce 6 Other (Spending occurred)	ecify)		
OU	ding th. : Afte fune	tior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		(? Yes 2 □ No		,,			
İSİ	Attending ir death. ector: After by the fune	ifica	a Cuicido 6 Could not be	8e. Place of Injury - At home,	farm, str	eet, factory, office	2		eet and Number or F	lural Route Number,		
Ö	elor A s after st Director	Certification:	4   Hollicide	building, etc. (Specify)				City or Town,	State)			
	To the Hospitel or Attending Physicien: The I within 24 hours after death.  To the Funnel Director: After this certificate he completely filled in by the funeral director, page	edical (	29a. Certifier  (Check only 2 Medical Examiner:	en: To the best of my knowled On the basis of examination	ige, death	occurred at the tim	ne, date and place, a	nd due to the car	use(s) and manner a	s stated.		
	the H iin 24 the F tplete		one)	and manner stated.	and/or in							
ı	To To	Σ	29b. Signature and title of certifier			29c. License	4 4		d. Date signed (Mon	th, Day, Year)		
			Kan	m1)		126	168		7/1/0			
	6		30. Name and address of payson who comp  M  DOENGAC	28/6. No	zu.		69768 Risny Su	a pul	0 219	1/		
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 0 2005	32. Begistrar's Signature	- Go	BOSE!	•					

			, rui	artment of Health and Me	ental Hygiene	5 17210
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Wilbur Earl Barkdoll Jr.		Date of Death May 10 <sup>Day</sup> 2005	
	Examin		4a. Facility Name (If not institution, give street and number) 12263 St.Paul Road	4b. City, Town, or Location of Death Clear Spring		ngton
	Funeral Director		5. Social Security Number 215-36-6852 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 1 M 2 F 84 Yrs.	Months Days Hours Min. 8	(Month, Day, Year) Q 2 Q	Birthplace (State or Foreign Country) PA
	Maryland -f show fied at	tor	10a. State Nashington 10c. City, Town or L			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	h with the 23a or 28a st be roll	ai Director	10e. Street and Number 12263 St.Paul Rd.	10f. Zip Code 21722	10g. Citizen of What U.S.A.	Country?
036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23a or 28a-f show o'dother than "natural", or Items 23a or 28a-f show evant, the Medical Esartinar must be recitied at	by Funeral	11. Marital Status  1 Never Married	Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ric	ty Yes or No- can, etc.) 14. Race - A Black, W Specify: W	
Maryland 21215-0036	d within 72 ho giene. or then "natu	Completed	(Specify only highest grade completed) (Giv.	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) airy farmer	16b. Kind of Busine self/e	ss/Industry mployed
/land	2 should be filed and Mental Hygid Is marked other aumatic evant, II	To Be C	17. Father's Name (First, Middle, Last) Wilbur Earl Barkdoll Sr		First, Middle, Maiden Sumame) rene Hartle	
	d 2		Goldie V.Barkdoll wife 122	ing Address (Street and Number or Rural F 63 St.Paul Rd.Cle	ear Spring,MD	21722
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other once.		'4 □Donation 5 □Other (Specify) St. Pau	nmatory or other place) 1 Cemetery 2005	5 Clear S	pring MD
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Donald Edwin Thor P.O.BOX 310 Clear	mpson Funeral r Spring,MD 2	Home,Inc 1722
	Physician and business busines	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or head failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	- metasta  metasta  metasta	espiratory arrest,	Approximate Interval Between Onset and Death  3 Month
.O. Box 68760,	the death certifi y the attending iched for use as	Physician/Medical E		□Ectopic pregnancy □ Other (specify)	23d. Date of Month	delivery Day Year
rds, P.	sign of be	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part !.	23e. Did tobacco-use contribute	e to the cause of death?  Probably 4  Unknown
Vital Records,		Completed			autopsy prior performed?" death	autopsy findings available to completion of cause of ?? 'es 2 \( \text{No} \)
of	ling Phys	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 EP/Outpatie  27. Manner of Death 1  Accident investigation  (Month, Day Year) Injury		V.	(pecify)
Division	ital or Attand rs after death al Diractor:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office 281	f. Location (Street and Number or City or Town, State)	Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, deal control on the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred	at the time, date and place, and c	due to the cause(s)
)	vit To	4	29b. Signature and title of certifier	D46473	29d. Date signed (Mo	05
اك	4-7		30. Name and address of person who completed cause of death (Item 23a) (Type	130 OPAL CT	1. Hagers	town, MD
6	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature /	1	, )	-

			1 - For State Registrar	State of M	larylan	•	artment rtificate			d Men	-	giene Reg. No	2001	172	
	Dhysiai		1. Decedent's Name (First, Middle, Las	t)							Date of De	ath Da	y Yea	3. Time of D	eath
4	Physici /Medic		Elva	Robert	ta	Brote	markle						2005	3:25	<b>A</b> M
7	Examin	er	4a. Facility Name (If not institution, give		)				cation of De	ath	1	4c. County of Death			
			Lions Manor Nursin			January Control of the	Cumberland  If Under 1 Year   If Under 24 Hrs.   8 Date of				Allegany				
	Funeral Director		5. Social Security Number 6. Sr 214-07-3022	9X		last birthday) Yrs.			lours Mi	in. (	Nate of Bir			irthplace (State or F Country)	-oreign
			Usual Residence of Decedent		91					[01,	/08/19	14	Ma	ryland	
	yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City	Limits
	P-f sl	io	MD Allegar	ny		Cumberl	and.							1 Tes 2	No No
	or 28	Director	10e. Street and Number				10f. Zip C					10g. Ci	tizen of What (	Country?	
	within 72 hours after death with the Maryland ene. than "netural", or items 23a or 28e-f show I.a Modical Examinar must be mullied at		14207 Bedford Ro	ad, N.E.				21502	2				USA		
	tems ferms	Funerai	11. Marital Status	12. Was Decedent Armed Forces	Ever in U	.S. 13.	Was Deceder f Yes, specify	nt of Hispa Cuban, N	nic Origin? fexican, Pu	(Specify erto Rica	Yes or No	)-	14. Race - An Black, Wh	nerican Indian, nite, etc.	
36	or i	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X☐ If Yes, Give			1 ☐ Yes 2		pecify:				Specity:		
8	hour tural	pa pa	15. Decedent's Eq	Year or Dates:		16a Doco	dont's Liqual	Competion				105 1		hite	
21215-0036	in 72	Completed	(Specify only highest gra	de completed)		(Give	dent's Usual ( kind of work DO NOT use	done durin	ng most of w	vorking		100. K	and of Busines	s/industry	
212	with jiene.	mo	Elementary/Secondary (0-12)	College (1-4or	5+)	Hot	memaker						Homema	ker	
D	illed I Hygid other	Be C	17. Father's Name (First, Middle, Last)			1101	ilicinatic 2	18.	Mother's N	lame (Fir	st, Middle,	, Maider			
lan	ould be filed with Mental Hygiene. arked other than atic event, It e.M.	To B	Charles	E1swo	rth	Dral	ке	]	Edna		Earl		Le	asure	
Maryland	she and and and and and and and and and and		19a. Informant's Name/Relationship (7	Гуре, Print)		19b. Mailie	ng Address (S	Street and	Number or	Rural Ro	ute Numbe	er, City	or Town, State	, Zip Code)	
	Health Health tem 27 i		C. Lee Brotemarkle /	son					, N.E.,	Cumb	erland	d, Ma	ryland	21502	
Baltimore,	permit. Pages 1 a Department of Hea Importent: If item any injury or othe once.		20a. Method of Disposition 1	Removal from State		Place of Dispo cemetery, crei	sition (Name natory or othe	of er place)	1	Date	İ	20c. L	ocation - City o	or Town, State	
Ē	Pages ment of I tent: If its lury or o		'4 □Donation 5 □ Other (Specify		1	on Memor				24/200	5	Cu	mberland	, Maryland	
3all	permit. Departm tmporte any inju		21. Signature Fundral Service Licen	see C		) 22	. Name and					2	meral Ho		
	005 e 0		- Lilet	-Clas	ns								ryland	21502	
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that cause one cause on each	d the deat line.	th. Do not ent	er the mode	of dying, s	uch as card	liac or res	piratory a	rrest,		Approximate Interval Betwe Onset and De	
}	Physician		Immediate Cause (Final disease or condition resulting in death)	aM.	etes	fort c		0180	nom	a			1	Vic	201
	/Medical Examiner		1	Due to (or as	s a conseq	quence of):									
		-	Sequentially list conditions,	b. Due to (or as	a cunseq	ruence of).									
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events												
oʻ.	exec an an		resulting in death) Last	Due to (or as	s a conseq	quence of):									
8760,	ate be executed physicien and the burial-transit	dicai		d											
9	ng ph	Med	IF FEMALE:												
Вох	leath certific attending p	an/N	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pred	nancy					23d. Date of d	,	
	it the dea by the at tached fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant a 9☐Unknown	at time of o		Other (spec						Month	Day Yea	).
P.0	that the		Part II. Other significant conditions o	ontributing to donth	but not roo	udina is the	adashias sau		Don't		ana Diale	abassa .	una annteibuta	to the cause of dea	15.0
ds,	sign sign d be	1 by	Tarric stagning and and and a	ontributing to death	Dat Hot 193	anny in the a	nuerlying cau	se giveri ii	raili.			Yes 2	_	Probably 4 Uni	
Ö	v requ	etec											T	. //	
of Vital Records,	has has	Completed		· -						-	24a. Was autor		24b. Were prior to death?	autopsy findings ava completion of caus	ailable se of
a			OF Man and address of the second address of the second and address of the second and address of								1 ☐ Yes	2 X No	1 □ Ye		
₹	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital: 1   Inpat	iont 2	TER/Outpation	a	Other:	. Place of D				0 TO: 10		-
		.: To	27. Manner of Death	28a. Date of Inj (Month, D		28b. Time of		. Injury at Work?	4 A Nursing			_	6 □Other (Sp ry occurred	есіту)	
ion	결국물	atlo	1 Natural 5 Pending 2 Accident investigation		ay Year)	Injury	М		2 🗆 No						
Division	l or Attendii after death. Director: Al in by the fu	ifica	3 Suicide 6 Could not be determined	28e. Place of In	njury - At h	ome, farm, str	eet, factory,	office						Rural Route Numbe	r,
Ö	tel or A	Certification:	110010	bullaing, e	tc. (Specil	7/				(	City or Tov	wii, State	3/		
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune		(Check only 2 Medical Exan	ysician: To the bes	t of my kno	owledge, deatl	occurred at	the time, o	date and pla	ce, and c	tue to the	cause(s	) and manner :	as stated.	
	To the h within 24 To the F complete	Medical	one)	and manner s	tated.										
	,	~	29b. Signature and title of certifier					License nu	.047	0		1 :		oth, Day, Year)	
7	2		and v		4	- 00 : -		0000	- 7	3		Ma	4	, 2005	
	nls		A fag Ahmad	,MD (	025	Kent	Aver	me	Cu	nbe	rla	nd,	aM	21502	ζ
	Sta Registi		31. Date filed Worth, Day, Year) MAY 1 9 20	05 37 Hegist	trar's Signa	ante	ever								

			Star Star	e of Maryland /	Department			jiene	
A	mended	it	State Registrar #7, per/f. hom  1. Decedent's Name (First, Middle, Last)	e, 5/10/05,	Certificate	of Death	E.T, WCHD R	leg. No.	3. Time of Death
	Physici		Gladus Bo	Mard	Brown	1)	Month $\Lambda$ 5	Day Year	0
	/Medic Examir		4a. Facility Name (If not institution, give street as	nd number)		own, or Location o		4c. County of Dea	
			S. Social Security Number 6. Sex	Medical Cu.	birthday) If Under 1	Vear Hunder	24 Hrs   0 Days of Birds	Wicom	
	Funeral Director		205-14-9231 1 1 M 25			Days Hours	Min. 8. Date of Birth (Month, Day	Year) 9. Bi	rthplace (State or Foreign ountry)
	pur *		Usual Residence of Decedent  10a. State 10b. County	100 City To	own or Location		₩ <b>€</b> 0		Land heids On the in
	h the Maryland r 28e-f show	ŗo	mds	0.					10d. Inside City Limits 1
	or 28e	Director	10e. Street and Number	- 11110	101. Zip		1	log. Citizen of What C	ountry?
	ath wi	rai	11300 Somerset	Avenu	21	1853		U.S.I	4.
-10	ter dea items	Funeral	Arm	Decedent Ever in U.S. ed Forces? Yes 2 TNo	13. Was Decede	ent of Hispanic Orig fy Cuban, Mexican	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - Am Black, Wh	
5-0036	ours af	þ	3 Widowed 4 □ Divorced Yea	Yes 2 TNo es, Give r or Dates:	1 □ Yes 2	No Specify:		Specify: B	lack
15-0	filed within 72 hours after death with the Maryland Hygiene. uther then "natural", or Items 23e or 28e-f show ont, Item offical Examinational be notified at	Completed	15. Decedent's Education (Specify only highest grade compl	eted)	Sa. Decedent's Usual (Give kind of work life. DO NOT use	done durina most	of working	New Yo	s/Industry
212	s within	ошо		ege (1-4or 5+)	1 Eac	1		Road of	Education
pu	oe filed w tal Hygier d other th	Be C	17. Father's Name (First, Middle, Last)	1 / /			r's Name (First, Middle,	Maiden Sumame)	Columnia
Maryland 2121	2 should be filed withir and Mental Hygiene. is marked other then aumatic event, Italia.	P	George Da	llard_			ecca 1	Rell	
Ma	s 1 and 2 should be filed within 72 hc f Health and Mental Hygiene. item 27 is marked other then "natur other traumatic event, Ite M. Accal		19a. Informant's Nama Relationship (Type, Print Gertrude Stevens	(Fam. 13	D 14 1 M	Street and Numbe	r or Rural Route Numbei	r, City or Town, State,	Zip Code)
ore,			20a. Method of Disposition	cama	of Disposition (Name tery, crematory or oth	e of her place)	Date	20c. Location - City o	r Town, State
3altimore,	nit. Page vartment o ortant: If injury or		1 Burial 2 □ Cremation 3 □ Removal 4 □ Donation 5 □ Other (Specify)	John John		y Con. 5	-14-05	FINCESSON	we md.
Bai	permit. Pag Department Important: any injury once.		21. Signature of Fineral Service Licensee	£C_	Bernie	Smith -	Funeral H	carc	
			23a. Part1. Enter the disease, or complications	that caused the death. De	POL	30 x 53 1	POSOMOKE	City Ma	Approximate
M	Physician		shock, or hear Vailure. List only one cause Immediate Cause (Final disease or condition		REBRAL	- INF	ARCT		Interval Between Onset and Death CHD AUS
	/Medical Examiner		resulting in death)	ue to (or as a consequenc	e of):				
		e	Sequentially list conditions, b	HYPERTE I					204EARS
	cuted nd ransit	Examiner	Sequentially list conditions, and product and conditions are cause. Enter Underlying Cause (Disease or injury that initiated events c.						
90,	ate be executed hysician and the burial-transit		resulting in death) Last	ue to (or as a consequenc	e of):				
68760	ate hys	edicai	d						
Box (	requires that the death certific een signed by the attending p hould be detached for use as	an/Me	23b. Was decedent pregnant	s, outcome of pregnancy Live birth 2 Petal dea	th 3□Ectopic pre	anana.		23d. Date of de	livery
	it the deal by the att tached for	Physician/M	1 Vas 2 No	Pregnant at time of death Unknown	5 ☐ Other (spe		<del></del>	Month	Day Year
P.0	that the	/ Ph	Part II. Other significant conditions contributing	to death but not resulting	in the underlying car	use given in Part I.	23e. Did tol	pacco use contribute t	o the cause of death?
rds	n requires been sign should be	Completed by	RHABDOMYOLY				1 🗀 Ye	es 2⊠No 3⊡P	robably 4 Unknown
eco	aw as b 2 si	piet	BACTREMIA				24a. Was a	n 24b. Were a	utopsy findings available completion of cause of
al B	(0 (1						perform	ńed? death? 2⊠No 1 □ Yes	
V.	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital:	1 ☑ Inpatient 2 ☐ ER/0	Outnationt 3 DOA	0.1	of Death (Check only on sing Home 5 Reside		naife)
Division of Vital Records,	ding Phy I. After thi funeral (	T :uc				c. Injury at Work?		w injury occurred	KAIY)
Sio	tend Jeath tor: the	icatio	2 Accident investigation		М	1 □ Yes 2 □ N			
Div	II or Atten after deat Director: d in by the	Certification:	4 Homicide determined 286.	Place of Injury - At home, building, etc. (Specify)	farm, street, factory,	office	City or Town	reet and Number or R n, State)	ural Houte Number,
	To the Hospital or Al within 24 hours after o To the Funeral Direc completely filled in by	edical C	29a. Certifier 1 Certifying Physician: 1 Medical Examiner: On	o the best of my knowled	ge, death occurred at	t the time, date and	I place, and due to the ca	ause(s) and manner a	s stated.
	To the H within 24 To the F complete	Medi	one) and 29b. Signature and title of certifier	manner stated.	200	Liannea aumhar	2	Od Data signed (Mos	
	7 <u>№</u> 7 8	_	250. Signature and title or common	Egn, 14.	2	D469	762	MAY O	7,2005
	- 0		30. Name and address of person who completed	cause of death (Item 23a					
$\mathcal{E}_{\cdot}$			30. Name and address of person who completed  M. S. H.I.R.A. Z.I., M.D.  31. Date filed (Month, Day, Year)	27 Posistrada Cispatura		10NHL	- TO DICHE	- EIFICK'	
	Sta Registr		MAY 1 0 2005	32. Aegistrar's Signature	South				

			1 - For State Registrar	State	of Maryla		artment of	Health and I		4000	17213				
	1. Decedent's Name (First, Middle, Last)						timouto o	7 2 0 4 11 7	2. Date of Death		3. Time of Death				
	Physician Patsy Jane						Brakeal	1	May 15,	Day Year 2005	5:36 a. M				
/Medical Examiner 4a. Facility Name (If not institution, give street and								, or Location of Deatl		4c. County of Dea					
		Memorial Hospital					CUMBER	LAND		ALLEGAN	LLEGANY				
	Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last				s. last birthday) Yrs.	If Under 1 Yea Months Day		8. Date of Birth (Month, Day, )	9. Birthplace (State or Fo						
	Director		217-30-6407 1□ M 2໘F 72						09/16/1932		Maryland				
	and and	tor	Usual Residence of Decedent  10a. State 10b. County		10c. C	City, Town or Lo	cation				10d. Inside City Limits				
	Mary if sho		WV Mineral Wiley Ford 1∑Yes 2□N												
	the 286	Director	10e. Street and Number	g. Citizen of What C	ountry?										
	3e or		Route 1 Box 24				10f. Zip Code	767							
	death	Funeral	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13. )	Was Decedent of	Hispanic Origin? (S	pecify Yes or No-	USA 14. Race - Am	erican Indian,				
9	after or ite	Fur	1 ☐ Never Married 2 ☑ Married	orces?	2 [7] No		ıban, Mexican, Puert	o Rican, etc.)	Black, Whi	te, etc.					
8	ral', c	1 by	3 Widowed 4 Divorced	11 1 05, G	ar or Dates:		I□Yes 2ሺN	o Specify:		Specify:	White				
21215-0036	72 h	To Be Completed	15. Decedent's E (Specify only highest g	)	(Give	ient's Usual Occ	e durina most of wor	kina 16	b. Kind of Business	f Business/Industry					
7	/ithin		Elementary/Secondary (0-12)	(1-4or 5+)	life. L	DO NOT use reti	red)								
2	lled v lygie her t		12		Tea	acher	40. 34-15-1-31-	- /Fi 15id#- 15	Public Scho	ools					
and	ontal h									(First, Middle, Maiden Surname)  Irene Wilhide					
Maryland	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. In marked other than "natural", or Items 23e or 28e-f show aumatic event, the Medical Examinar must be notified at		Roger Jacob Lay  19a. Informant's Name/Relationship			10h Mailin	a Address /Stra	Hilda et and Number or Ru	Irene						
<u>8</u>	d 2 s th an t7 le i traui		Benny R. Brakeall		ì			, Wiley For							
ē,	Heal Heal tem 2		20a. Method of Disposition	, ildobalic			sition (Name of natory or other p			c. Location - City or					
JO L	permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 is marked any injury or other traumatic as <u>once</u> .		1 XBurial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Specific Specific	State			1	2/2005	0 1 1 1	W - 1 1					
altimore,	orter Injur		21. Signature of Full eral Service Lice	-	Su		orial Park . Name and Add	ress of Facility Ad	9/2005	Cumberland	Mary Land				
ä	Per Per Per Per Per Per Per Per Per Per		* Kelent C.	ellam											
			23a. Part 1. Enter the disease, or complications that caused the death. Oo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between												
	Pnysician		Immediate Cause (Final disease or condition	M	11-	L. L.	1-1	10 /	- C	.020	Interval Between Onset and Death				
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  A. Due to (or as a consequence of):								GUNNOWN					
В			Sequentially list conditions,	b	b										
	p =	Examiner	if any, leading to immediate	Due to (or as a consequence of):											
	e be executed rsician and e burial-transit	cam	Cause (Disease or injury that initiated events resulting in death) Last	C.											
60,	cate be executed physician and the burial-transit			Due to (or as a consequence of):  d.											
58760,	<u>a</u> £ £	//Medical													
ox e			IF FEMALE:	23c. If yes, or	tcome of pregr	nancy			22d Date of do	livon					
ă	death certif e attending id for use a	clar	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 10 6  4 Pregnant at time of death 5 Other (specify)							Month Month	23d. Date of delivery  Month Day Year				
o.		Physician/M	9 Unknown	9□ Unkr											
ر. ت	law requires that the as been signed by th 2 should be detache	by PI	Part II. Other significant conditions	contributing to	23e. Did toba	23e. Did tobacco use contribute to the cause of death?									
ğ	w require been sig should b				1 ☐ Yes	1 Yes 2 No 3 Probably 4 Uaknow									
ecords,	aw re	Completed							24a. Was an	24b. Were at	utopsy findings available				
T	9 4 9	E O							autopsy performe	d? death?	completion of cause of				
Vital	ılcian: Th certificate rector, paç	BeC	25. Was case referred to medical 26. Place of Death. Check and, one												
of <	hyelci this cer al direc	2	examiner?												
ב	ding Ph h. After th funeral	on:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time of lnjury at Work? 28d. Describe how injury occurred									
<u>S</u>	or Attending Phyelcian: uter death. Director: After this certific in by the funeral director,	cati	2 Accident investigation 3 Suicide 6 Could not				JYes 2□No								
Division	or Attencater death of Director:	Certification	4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	pital		200 Codifice 1 Descripting Physician T. Habert Co.												
	To the Hospital o within 24 hours aff To the Funeral Di completely filled in	Medical	29a. Certifier  (Check only one)  1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	ro the vithin ro the ro the ro the romple	Me	29b. Signature and title of certifier	0//	7		29c. Lice	nse number	29d	. Date signed (Mont	h, Day, Year)				
5 May 18,								ay 18, 20	2005						
	)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)													
_	nes			,			·	Cumberland,	Maryland 2	1502					
	Sta	4	31. Date filed (Month, Day, Year) MAY 18	32. I	distrar's Sign	nature	4								
	Registr	ar	MAITO	2003		IS A	THE STATE OF THE S								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 05/08/2005 ar **Physician** Edward Joseph Burns 4:20PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico 35184 Diva Court Pittsville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 6. Sex 1 XM 2 ☐ F 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 03/2874922 83 220-03-8046 MD Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, it is Medical Exemplementation to colling at 1 Yes 2 No MD Wicomico Pittsville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 35184 Diva Court 21850 USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 2 Yes 2 □ No If Yes, Give 1 Q 1 1 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married Married 1 ☐ Yes 2 XNo Specify: by If Yes, Give 1941 Year or Dates: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Salesman Beverage 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Burns Margaret Hartman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Ruth Burns 35184 Diva Court Pittsville, MD 21850 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Cape Henlopen Crem 05/13/2005 Frankford, DE \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ullrich Funeral Home 10902 Ocean Gateway Berlin, MD 21811 Part1. Enter the disease, or complications, or head failure. List only one not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Pue to (or a a consequence of): Pnysician 1 110N/L disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Litter or deriving Cause (Disease or injury Due to (or as a consequence of). Examiner law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9☐ Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? this certificate has I rmed? 2 No 1 Yes 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier H44283 05/10/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Durkin MD 9733 Healthway Drive Berlin, MD 21811 31. Date filed (Month, Day, Year) MAY 1 0 2005 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien

					State of M	arylano	Certific			Mentai riy	Reg. No.	05	17215	
	Physicia	an	Decedent's Name		1	2				2. Dete of De Month	Day	Year	3. Time of Death	
1	/Medic	al .	Robe:		ise Bear				4b. City, Town, or		13, 2005 th 4c. County		6:00 pm	
	Examin	er	Devlin			Iome			Cumber			gany		
	Funeral Director		5. Social Securify Nu 218–12–588	87 1	ex 7. Ag □M 2 <b>j</b>	je (In yrs. le 83	st birthday) If Ur Yrs. Mont	hs Days			rth ay, <i>Year)</i> 8 1921	9. Birthplac Country West V	e (State or Foreign Virginia	
	tand ow		Usuel Residence of 10a. Stete	dence of Decedent  10b. County  10c. City, Town or Location							10d.	Inside City Limits		
	the Marylar 28a-f show notified at	ctor	MD.	Garrett		В	loomingto	on					XIXYes 2□No	
	th with the 23a or 28	ai Dire	10e. Street and Number  Box 31 Owens Ave.  10f. Zip Code 21523  United							What Country State				
Maryland 21215-0020	permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Maryland Department of Health end Mentel Pygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Marrie 3 □ Widowed	_	12. Was Decedent Armed Forces? 1 D Yes 200 If Yes, Give Year or Dates:	Ever in U,S No			Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or Note Rican, etc.)	o- 14. Rac Blac Specify	e - American ck, White, etc Whit	•	
5-0	72 hc	eted	(Speci	15. Decedent's Edify only highest gra	lucation de completed)		16a. Decedent's U (Give kind of life. DO NO	Jsual Occup work done	pation during most of wo	orking	16b. Kind of Bu	usiness/Indus	stry	
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b	e filed el Hygi other vent, I	Be C	17. Father's Neme (				, Maiden Surname)							
<u>ya</u>	should bent Ment	2	James		enbaker			(0)	Lydi		rke	Chata 7in Co	odol	
Mai	id 2 sh lth end 17 is m traum	1	19a. Informant's Na Melanie	Martin/	• • • • • • • • • • • • • • • • • • • •			-	tand Number or R Drive,		rg, Mary		21532	
Baltimore,	beges 1 er ent of Hea it: If Item 3 y or other		20a. Method of Disp 1  ☐ Burial 2	osition	Removal from State		ace of Disposition (metery, crematory)	Name of or other pla		Date 05/16/	20c. Location -	City or Town	, state Jaryland	
Balti	permit. F Departm Importar eny inju	21. Signafure of Funeral Service Licensee 22. Name and Address of Fecility Boal Funeral Home										21562		
			23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  21562  Approximate Interval Between Organical Death.											
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90,	ificate be executed g physician and as the burial-transit	edicai Examiner												
ox 68760,	Attending Physician: The law requires that the death certificate be executed robath. robath. ector: After this certificate has been signed by the ettending physician and by the funeral director, page 2 should be detached for use as the bunal-transit	- 1										. 48		
œ.	death e etter	siciai	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did to							l tobacco use co	obacco use contribute to the cause of death?			
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Division of Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours efter death.  To the Funeral Director: After this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be detached for use as	Completed by Physician/N	865+	ruitius	pulmon Frilus	nong	hsen	· · ·	with	24a. Wa	s an autopsy formed?	24b. Were availa comp of de	autopsy findings able prior to eletion of cause ath?	
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ital	ian: T	Bec	25. Wes case referr exeminer?						26. Place of De	eath (Check only				
of <	hysic this ce al dire	-T	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Hospital: 1 Doal Other (Specify)											
5	ding F th. After funer	tion	27. Menper of Death  1. Auturel  2 Accident  3 Suicide  4 Homicide  28b. Date of Injury (Month, Dey Year)  28b. Time of Injury M  28b. Time of Injury M  28b. Time of Injury M  28b. Time of Injury M  28b. Time of Injury M  28b. Injury et Work? 1 Yes 2 No  28b. Location (Street and Nur City or Town, State)											
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	Hospita 24 hours Funeral letely fille	dical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es steted. 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted.											
_	£ 15 £ 6 29b. Signature end title of certifier							29c. License number				29d. Date signed (Month, Day, Year)		
							2124	4 5/16/2005						
	TAS.		30. Neme end eddre Dr. Jes	ess of person who us Tan, I	completed cause of Prostburg	deeth (Item Plaza	23a) (Type, Print) Frostbi	ara,	Maryland	21532				
	Sta Registr		31. Defe filed (Mont	th, Day, Year)		rer's Signati	·							

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20<u>05</u> **Physician** Month Year May Shirley Boyer 12:31 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick 7201 Peekskill Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 😿 F Director 70 Yrs. 217-30-6314 March 3, 1935 Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location or 28e-f show r than "netural", or Items 23a or 28e-f shov the Wedest Examinate untibe notified at 1 ☐ Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 7201 Peekskill Drive 21702 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after or Hygiene. 1 Never Married 2 Married 1 ☐ Yes 250 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No by Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fill Department of Health and Mental Hy importent: If item 27 is marked oth any Injury or other traumatic event Millard Dansberger Lulu Hunichen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Boyer - husband 7201 Peekskill Drive, Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Olivet Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 5/10/2005 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee Sharow anulle 1621 Opossumtown Pike, Frederick, Maryland 21/02 allere Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) months Physician rimary /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 4☐Pregnant at time of death detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' certificate 2 **3** No 1 Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 Natural 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funerel 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number other D0036610 Maro 30. Name and address of person who completed caule of death (Item 23a) (Type, Print) MD JOHNSON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 1 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 2005 7:45 A Joseph E Brooke May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health Of Bethesda Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 96 08/18/1908 Director 579-01-0633 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural;" or Items 23a or 28a-f show eny injury opether traumatic event, the Marked Examinar must be rediffied at opice. 10d. Inside City Limits 10c. City, Town or Location 1 X Yes 2 No Director MD Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 615 Hollywood Avenue United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 ☐ No WW II If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. þ 3 ☑ Widowed 4 ☐ Divorced White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) Plumber Plumbing 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Brooke Blanche Houston 19a. Informant's Name/Refationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12922 Georgia Avenue Silver Spring, MD 20906 Marie Satterwhite - Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Buriaf 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 05/12/2005 Suitland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. la 11800 New Hampshire Ave Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Colon Cancer /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy certificate 2 X No 1 Yes After this certification, funeral director, Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗀 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a To the Funeral [ 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier MID D-27660 6/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alpana Coswami, MD 11119 Rockville Pike Suite G-100 Rockville, MD 20852 3 Registrar's Signature 31. Date filed (Month, Day, Year) State Registra

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36	4 within 72 hours after death with the Maryland Jiene r then "natural", or items 23a or 28e-f show the Medical Exeminat must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 🎖 Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1	? ∮No	.S. 13.			spanic Ori n, Mexican Specify:	gin? (Spe , Puerto l	cify Yes or N Rican, etc.)	0-	14. Race - Black, Specify:	White, e	tc.	
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.O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta	death 3	⊒Ectopic ⊒ Other (s	pregnancy specify)					23d. Date of Month		y Day	Year
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of V	Physicien: this certific ral director,	To B	examiner? 1 D Yes 2 2 No	Hospital: 1 ☐ Inpa	tient 2 🗆	ER/Outpatie			4 🔲 190		ne 5□Res	_		(Specify)	nosp	ice
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			For State Registrar	State of Ma	ırylan		artmen rtificat			and Me	ental Hy	/giene	005	172	19
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920	be filed within 72 hours after death with the Maryland tal Hyglene d other than "natural", or iteme 23a or 28e-f show event, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent & Armed Forces?  1 ⊠Yes 2 □ N If Yes, Give Year or Dates: W	lo		Was Deced f Yes, sped 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spec i, Puerto R	offy Yes or N lican, etc.)	0-	14. Race - Ame Black, White Specify: Wh	e, etc.	
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month MAY 2005 **Physician** 4 8:15 P M AGNES GLYNN BLADEN /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner GAITHERSBURG MONTGOMERY WILSON HEALTH CARE CENTER 8. Date of Birth (Month, Day, Year) June 1 1910 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F 94 Yrs. Director 578-44-3770 Virginia Usual Residence of Decedent fited within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location in than "neturel", or items 23e or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Md. Derwood Montgomery Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 20855 17416 Redland Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ੴNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 De Yo Specify: White 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Nurse permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Importent: If Item 27 is marked other it
eny injury or other treumatic event. Ithe 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lady Thacker Emma Kennon Jinks S. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Larry K. Withers / Son 17416 Redland Road, Derwood, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 5/26/05 Arlington, Virginia <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) Arlington National 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home marie Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Recent cerebrovascularaccedent Pnysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last -transit Due to (or as a consequence of) rsician al e burial-t Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes P.O. | 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, acteurtesexe. Mone 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ug. Chronce anemica performe posterntestin 2□ No 1 Tyes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 1 Yursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ☐ ER/Outpatient 3 ☐ DQA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospitel or Attending 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical 29c. License number 29b. Signature and title of certifier 14 Raputto ddress of person who completed cause of death (Item 23a) (Type, Print) 20/ RUSSELL BIRICHBACK WAS 31. Date filed (Month, Day, Year) 3. Registrar's Signature State MAY 0 9 2005 Registrar

		1	For State Registrar	State of N	/laryland	d / Depa <i>Cei</i>	artment of H tificate of I	ealth and N Death		Reg. No.	2005	17221
		1	Decedent's Name (First, Middle	, Last)					2. Date of De Month	Day	Year	3. Time of Death
	Physicia		Harold Mil	es Brando	n				May 6,		county of Death	5:20 p M
	/Medica		la. Facility Name (If not institution	, give street and number	er)		4b. City, Town, or	Location of Death				
			Suburban Hos	pital			Betheso	la If Under 24 Hrs.	8 Date of Bi		ntgomer	place (State or Foreign
	Funeral	5	5. Social Security Number	6. Sex 7. 1 X M 2 ☐ F	Age (In yrs. la	ast birthday) Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D. Oct 7		Cou	<sub>ntry)</sub> aska
	Director		574-05-3259	72.11	80				OCL 7	, 192		
	pu »	-	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	ocation					10d. Inside City Limits
	eho eho	5			Sil	ver S	orina					1 Tyes 2X No
	the N	Director	Maryland Monte	gomery		VCI D	10f. Zip Code			10g. Citiz	en of What Cou	intry?
	with page	<u>=</u>	10312 Folk Str	eet.			20902			U.S.		
	within 72 hours after death with the Maryland ene. than "natural" or itema 23a or 28a-f ehow the Marical Examirer aunt be natiliwd at	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.	S. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or N o Rican, etc.)		<ol> <li>Race - Amer Black, White</li> </ol>	, etc.
·0	fter o	표	1 ☐ Never Married 2 ☐ Mar				1 ☐ Yes 2 No			;	Specify: Ind	dian
ဗ္ဗ	al', o	by	3 X Widowed 4 Divorced	Year or Date	es: WWI			-ation		16b Kin	d of Business/l	ndustry
9	72 ho natur	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor d)	rking	100711		•
7	ithin nen M	du	Elementary/Secondary (0-12)	College (1-4	or 5+)		ercial Fi			Fis	hing	
7	ygier ygier her th	S	12 17. Father's Name (First, Middle	(ast)		COmm	erciar 11	18. Mother's Nar	ne (First, Middl	e, Maiden :	Su <i>mam</i> e)	
ind	be fi	Be						Beatri	ce Be	rry		
3	d Mer narke	2	James William  19a. Informant's Name/Relation	Brandon ship (Type, Print)		19b. Mail	ing Address (Street	and Number or Ru	ural Route Num	ber, City or	Town, State, Z	lip Code)
Maryland 21215-0036	12 sh h and 7 is n traur					1031	2 Folk St	reet, Si	lver Sp	ring,	MD 209	902
e, 1	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene for the them 23s or 28s-fehow item 27 is marked other than "natural", or Itema 23s or 28s-fehow other traumatic event, Ire Madical Examiner want be notified at other traumatic event, Ire Madical Examiner want be notified.		Juanita Tracy 20a, Method of Disposition		20b. P	Place of Disp	osition (Name of ematory or other pla	ace)	Date	20c. Lo	cation - City or	Town, State
20	nt of nit of or in it is		1 Denation 5 Other (	3 XRemoval from St Specify)	ate		rove Ceme		0/2005	Wisc	onsin [	Dells, WI
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service		/	2	22. Name and Addr	ess of Facility Fr	ancis J	. Col	lins Fu	neral Home,
Ba	Department of the population o		1904 d	Scent	27	5	00 Unive	rsity Blv	d, West,	Silve	er Sprip	ng, MD 20901
			23a. Part 1. Enter the disease, shock, or heart failure.	complications that ca	used the deat	th. Do not e	nter the mode of dy	ing, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
			Immediate Cause (Final	St Only One badge on the	k	ai>	NEY C	ANCE	R			3 years
	Physician /Medical		disease or condition resulting in death)	a. Due to (o	r as a consec	quence of):						/
	Examiner		3505-20	b								
	T (0) H	je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (d	or as a consec	quence of):						
	te be executed ysician and ne burial-transit	Examiner	that initiated events	C	or as a consec	cuence of):						
ó	a exe	E	resulting in death) Last	D09 t0 (c	n as a consec	4451100 017.						
3760,	ate be hysicine bu	lical		d								
.89	that the death certificate I ed by the attending physi detached for use as the	Physician/Med	IF FEMALE:	23c. If yes, outo	come of pregn	nancy					23d. Date of de	
Box	death ce	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bi	rth 2 ☐ Fet ant at time of	at death	B□Ectopic pregnan B□ Other (specify)	icy		_	Month	Day Year
0	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno								
₽.	hat the ad by detac	P	Part II. Other significant cond	itions contributing to de	ath but not re	sulting in the	underlying cause	given in Part I.	Į.			o the cause of death?
Js,	signe bed b	d by							. 1	Yes 2	<b>G</b> No 3□P	robably 4 Unknown
Record	The law requires that the site has been signed by the bage 2 should be detache	Completed							24a. W	as an utopsy	prior to	utopsy findings available completion of cause of
3ec	The law cate has l	dm							pe 1□ Ye	erformed?	death?	s 2 No
$\overline{}$			25. Was case referred to med	inal				26. Place of D	eath (Check on			
Vital	iciar certif recto	o Be	examiner?	Hospital	epatient 2[	☐ ER/Outpa	tient 3 DOA	Other: 4 Nursing	Home 5 R	esidence	6 □Other (Sp	ecity)
Be	Attending Physician: ir death. ector: After this certific by the funeral director,	-	7.5	28a, Date		28b. Time Injur		ijury at Vork?	28d. Descri	be how inju	iry occurred	
	ding P h. After funera	ţ	1 Natural 5 Per	nding (Monte	II, Day 16ai	III		☐Yes 2☐No				
Division	death death ctor: /	fica	3 ☐ Suicide 6 ☐ Cou	uld not be 28e. Place	of Injury - At	home, farm,	street, factory, office	CO CO	28f. Location City or	n (Street a Town, Stat	nd Number or F 'e)	Rural Route Number,
2	after Dire	Certification:	4   Homicide									
	o the Hospital or Attencitin 24 hours after death the Funeral Director:	alo	29a. Certifier 12 Certi	fying Physician: To the cal Examiner: On the b	best of my k	nowledge, d nation and/o	eath occurred at the r investigation, in m	e time, date and pla ny opinion, death oc	ice, and due to ccurred at the ti	the cause(s ne, date an	s) and manner and place, and du	is stated. ie to the cause(s)
R	the Ho hin 24 the Fu	edical	one)	and man	ner stated.			ense number			ate signed (Moi	
_	O T W	Σ	29b. Signature and title of cer	titier				516/6		IMA	. 4	,2005
			Atelana	·del-	MD			>   V   U		4.4		1
	511		30. Name and address of per	A	w 7	10	1.10 / 11	11/221	N	MODE	KALI	L
			31. Date filed (Month, Day, Y	9ar) JA	Registrar's Sig	populario A	and a	00000				
	Regi:	itate strai	T VANS	0 2005 See	we I	OF PA						

SANCEPT, RICHARD

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death HORK **Physician** ROBERT 2:09 A M CLANTON 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Baltinore Mercu If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min 1 □XM 2 □ F Yrs. Director 41 Aug. 21, 1963 Wash. 215-80-1472 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits show. 10b. County r than "naturel", or items 23a or 28a-f shor the Medical Examiner must be nutified at 1 Yes 2 No Prince George's Hillcrest Heights Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 3001 Ave., #629 20748 Branch death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify ģ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laborer Private permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygier Important: If Item 27 is marked other th any injury or other traumatic event, IIIs once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert O. Clanton, Sr Mary Chambers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3001 Branch Ave., #629, Hillcrest Heights, MD 20748 Yvette A. Clanton - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 5/7/2005 Landover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home ewas 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Eug-stage renal Disease The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequen 0 f) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ wection 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed? Yes 2 ☑No 1 ☐ Yes 2 ☐ No 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 1 ■ Natural 2 □ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: A 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MITENDING DS6 399 PHYSICIAN son who completed cause of death (tem 23a) (Type, Print) 301 ST. Paul ST 21201 NAZARIAN MD 31. Date filed (Month, Day, Year) Registrar's Signature\_ State MAY 0 9 2005 Registrar

			For State Registrar	State of Man		artment of He rtificate of De			iene <sub>eg. No.</sub> 200	5 17224
H	Physici		Decedent's Name (First, Middle, Las.  Helena	м.		Covello		2. Date of Deat Month May 5.	th Day Yea 2005	3. Time of Death 4:04 P
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or Lo	ocation of Death	Hay J,	4c. County of De	
	Zamin	· .	Fenwick Landing Assi	sted Living		Waldorf			Charles	
	Funeral Director		5. Social Security Number 6. Se 024-09-0451		in yrs. last birthday) 94		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, February (		irthplace (State or Foreign Country) SSAChusetts
	D		Usual Residence of Decedent					- COLUMN (		
	Marylar f show	tor	Maryland Prince Geo		Oc. City, Town or Lo Clinton	cation				10d. Inside City Limits 1 ☐ Yes 🏋 No
	with the 3a or 28a	l Direc	10e. Street and Number 11601 Glissade Drive			10f. Zîp Code 2073	35	1	0g. Citizen of What o	Country?
98	s 1 and 2 should be filed within 72 hours efter death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or feems 23a or 28a-f show other treumatic event, the Medical Enduriner must be notified at	y Funeral Director	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2√∑ No If Yes, Give		Was Decedent of Hisp If Yes, specify Cuban, 1 □ Yes 🕱 No	anic Origin? (Sp Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi	nerican Indian, nite, etc. White
9	hours tural',	ed by	X∑XVidowed 4 □ Divorced     15. Decedent's Ed	Year or Dates:	16a Dece	dent's Usual Occupation	n .		16b. Kind of Busines	
Maryland 21215-0036	filed within 72 Hygiene. Ither then "nation, the wedin	Completed	(Specify only highest grad Elementary/Secondary (0-12)		(Give	kind of work done dur DO NOT use retired) Secretary	ing most of work	king	ederal Gover	·
d 2	filed v Hygie Sther 1		17. Father's Name (First, Middle, Last)	z years			B. Mother's Nam		Maiden Surname)	
<u>lan</u>	should be and Mental is marked of sumatic eve	To Be	Adam Pilewicz				Michelena	Stacukie	ewicz	
lary	2 should and Men is marke eumatic		19a. Informant's Name/Relationship (7			ng Address (Street and			-	, Zip Code)
	of Health item 27		Carol L. Duble / Daug			l Glissade Dr	and the second		and 20735	or Town State
nor			XIXBurial 2 □ Cremation 3 □  '4 □ Donation 5 □ Other (Specify	Hemoval from State		osition (Name of matory or other place)	May9,			
Baltimore,	그 문 환 글		21. Signatur Funeral Service Licen			on Cemetery 2. Name and Address			linton, Mar las Fumeral	
m	Depared Impo		1 fy 1. 1.			6160 Oxon Hil				
	Pnysician		23a. Park. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	olications that caused the cause on each line.  a	e death. Do not en	ter the mode of dying,	010	or respiratory arm		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c	consequence of):		,			0
	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a c	consequence of):					
,0	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a c	consequence of):		<del></del>			
8760,	ate hy:	dica		d						
O. Box 6	The law requires that the death certifics the has been signed by the attending phoage 2 should be detached for use as I	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2™ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2   4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (s <i>pecify)</i>			23d. Date of o	lelivery Day Year
0	w requires that the bear signed by should be detact	by	Part II. Other significant conditions of	ontributing to death but r	not resulting in the u	nderlying cause given	in Part I.			to the cause of death? Probably 本基Unknown
I Records,		Completed						24a. Was a autops perform	y prior t ned? death	autopsy findings available o completion of cause of ? es 2 \( \) No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				th (Check only on	20.00	ed Living
of	Phys this ral dii	on: To	1 ☐ Yes 2 ☑ No  27. Manner of Death  1XXNatural 5 ☐ Pending	1 ☐ Inpatient  28a. Date of Injury (Month, Day Y		f 28c. Injury a Work?	t		ence 教文Other (S) ow injury occurred	pecify)
Division	r Attending er death, rector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		/ - At home, farm, st (Specify)		s 2 No	28f. Location (St City or Town	treet and Number or n, State)	Rural Route Number,
	ospitet or A hours after unere! Direc ly filled in by		29a. Certifier 1/2 Certifying Ph	ysician: To the best of			data and place	and due to the o	auco(s) and manner	as stated
	To the Hospitet or Attend within 24 hours after death To the Funerel Director: completely filled in by the	ledical	(Check only 2 Medical Exam	niner: On the basis of example and manner state	xamination and/or in	vestigation, in my opin	ion, death occur	red at the time, d	ate and place, and d	ue to the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier			29c. License n	number	2	9d. Date signed (Mo	ntn, Day, Year)
R	(19)		30. Name and address of ters in the or	completed cause of dea	th (Item 23a) (Type,	Print)	# 103	trush	ngo w	D 20744
ı	Sta Regist		31. Date filed (Month, Day, Year) MAY 1 0 200		s Signature	de			,	

Alexander Louis Chaufournier Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Unpend Item 23a,27,28a-f per me G844.6-9-05 tas

Certificate of Death

Reg. No. Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Alexander Louis Chaufournier May 11. 2005 7:35 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10017 Chapel Road Potomac Hours Min. April 26, 1 Montgomery County If Under 1 Year Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 □ F Yrs. Director 18 1987 216-47-9742 Washington, DC Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits rel', or Items 23a or 28e-f show Examiner must be notified at Y⊟Yes 2 No Maryland Montgomery Potomac Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10017 Chapel Road 20854 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pagas 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced "neturel" I Hygiene. other then "netur ent, the Wedical I Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pagas 1 and 2 should be ImDepartment of Health and Mental H
Importent: If item 27 is marked oft
eny injury or other traumatic ever Be 2 Roger L. Chaufournier Nancy Nicole Vultaggio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger L. Chaufournier / Father 10017 Chapel Road Potomac, Maryland 20854 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) May 18, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 2005 Comfort Crematory Alexandria, Virginia 21. Signature of Fugeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons, Inc., 5130 Wisconsin Ave. N.W. Washington, D.C. 20016 23a. Part1. Enter the disea, or complications that diused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failurs. List only one caus on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Oxycodone intoxication **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 4☐Pregnant at time of death Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕻 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an page 2 autopsy performed? certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 XOther (Specify) Scene 2 1 XYes 2 No 28a. Date of Injury
Foundth, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: unk After Found 7:25 1 Natural 5 Pending 1 ☐ Yes 2 🛣 No investigation Director: / 2 Accident 5-11-05 6X Could not be determined 3 🗌 Suicide 28f. Location (Street and Number of Rural Route Number, City or Town, State) 10017 Chapel Rd. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide Potomac, Md Scene 24 hours a 29a, Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME May 12, 2005 m.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mis 111 Penn Street Baltimore, Maryland 21201 LINLT . Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 7 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Day Month **Physician** p -м May 4, 2005 5:13 Jong Ok Chang /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George' Laurel Regional Hospital Laurel S If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months 1 ☑ M 2 □ F Yrs. South Korea Jan. 10. Director 214-25-6950 60 Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show itam 27 is markad other than "natural", or Itams 23a or 28a-1 show other traumatic avant, the Medical Exercit art must be notified at 1 ☐ Yes 2 No Maryland Anne Arundel Laurel Direct 10f, Zip Code 10g. Citizen of What Country? 10e, Street and Number 15 Little River Road 20724 South Korea Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2K Married 1 ☐ Yes 2 ☑ No Specify: Specify: Asian 9 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Owner Cleaners 6 permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othe any injury 0, other traumatic. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ok Sun Cho Woo Kwon Chang 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15 Little River Road, Laurel, MD 20724 Yong K. Chang/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State May 7, injury gr 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Memorial Gardens Davidsonville, Maryland ¹ 4 □ Donation 5 □ Other (Specify) 2005 21. Signature of Funeral Service Licenses Francis Address Collins Funeral Home Inc W.V 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 3 Years Lung Cancer resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisage or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician Physician/Medicai as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 1 P Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 2X No Attanding Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: I ☐ Yes 2🛣 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 K Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the after death 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ò To the Hospital within 24 hours a Example 1 Security in the past of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exemples: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical 29a. Certifier completely (Check only one) Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature

30. Name and address of person who Thomas A. Bensinger,

31. Date filed (Month, Day, Year, 6 0 2005

7525 Greenway Center Drive, #205, Greenbelt, MD 20770 32. Registrar's Signature

ompleted cause of death (Item 23a) (Type, Print)

M.D.

29c. License number

D08754

29d. Date signed (Month. Day, Year)

May 5, 2005

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

			State of Maryland / Dep	artment of Health and M	•	
			noglotte.	ertificate of Death		No. 2005 17227
ı	Physicia	an	1. Decedent's Name (First, Middle, Last)  CEDALD DISCRETE CASSET F		2. Date of Death Month	Day Year 4:38 M
	/Medid Examin	-	GERALD RUSSELL CASTLE  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Tring	4c. County of Death
		•	WASHINGTON COUNTY HOSPITAL	HAGERSTOWN		WASHINGTON
H	Funeral Director	0	5. Social Security Number 6. Sex $7$ . Age (In yrs. last birthday $219-44-3477$ $7$ . Age (In yrs. last birthday $7$ . Age (In y	Months Days Hours Min.	8. Date of Birth (Month, Day, Y FEB. 10,	(ear) 9. Birthplace (State or Foreign Country) MARYLAND
	ט		Usual Residence of Decedent		EED. IO,	
	larytar show	'n	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits 1 ☐ Yes 2 No
	72 hours after death with the Maryland naturel; or Items 23a or 28a-f show Jisal Esanither must be motified at	Funeral Director	MARYLAND WASHINGTON  10e. Street and Number	BOONSBORO  10f. Zip Code	10g	J. Citizen of What Country?
	th with	al D	6220 CASTLE ROCK DRIVE	21713		U.S.A.
	er dea	uner		. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
036	urs aft	by	1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 🖾 No Specify:		Specify: WHITE
5-0	J within 72 hours after death with the Maryian Jean. I than "naturel", or Items 23a or 28a-1 show Ite Model Examinet mast be mattled at	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired)	ing 16	b. Kind of Business/Industry
121	within ene. than "I	Juno	Elementary/Secondary (0-12) College (1-4or 5+)	SALES MANAGER		AUTO DEALERSHIP
d 2	Hyg Hyg ant,	Be Co	17. Father's Name (First, Middle, Last)		(First, Middle, Ma	
ylar		ToE	GERALD JAMES CASTLE	GOLDIE LI		
Maryland 21215-0036	C/ cg - cg			ling Address (Street and Number or Rura CASTLE ROCK DRIVE)		
			20a. Method of Disposition 20b. Place of Dis			c. Location - City or Town, State
imo	o = : •		1 X Burial 2 Cremation 3 Litemoval from State		3/2005 B	OONSBORO, MARYLAND
Baltimore,	permit, Page Department of Importent: If eny injury or once.			22. Name and Address of Facility BAST FUNERAL HOME		National Pike o, Maryland 21713
Г			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac of		
,	Pnysician /Medical		resulting in death)	cardial Intar	ction	3130t and 38ath
	Examiner		Due to (or as a consequence):			
	D #	iner	Sequentially list conditions, it also, teaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  c.			
_	be executed sician and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last   C			
200		calE	d			
9		ed	IF FEMALE:			
Вох	death certificat e attending phy ed for use as th	Physician/M	23b. Was decedent pregnant in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery  Month Day Year
o.	0 0 0	hysk	1   Yes 2   No 9   Unknown	Const (specify)		
s, P	se us	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of death?
Records,	w require been si should l	Completed			-	2 No 3 Probably 4 ¶Unknown
Rec	The law ate has I page 2 s	ldmc			24a. Was an autopsy performe	
Vital	(0 -	Be C	25. Was case referred to medical examiner?	26. Place of Death	1 Yes 2 (Check only one)	ZNo 1 □ Yes 2 □ No
of V	Physicien: this certific ral director,	P	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpati			ce 6 Other (Specify)
	ding h. After fune	tlon	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation		28d. Describe how	injury occurred
Division	or Attsnding after death. Director: Afte in by the fune	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	lospitel or At hours after o unerel Direc		29a. Certifier 12 Cartifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place	and due to the caus	se(s) and manner as stated
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Medical	(Check only 2 Madical Examinar: On the basis of examination and/or one) and manner stated.	investigation, in my opinion, death occurr	ed at the time, date	and place, and due to the cause(s)  Date signed (Month, Day, Year)
	To Cor	-	29b. Signature and title of certifier  Critical Do FACG	A 14 40 884		05 10 2005
5	1-10		30. Name and advess of person who completed cause of death (Item 23a) (Typ  Description 251 East Am	ietary St. Hog.	md. 7	1740
<b>;</b> ;	Sta Registi		31. Date filed (Month, Day Year) 2005 32. Paristrar's Signature	Goodes		
		10.00				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician May 2005 11:20 a.m. Flora Waneta CUSHEN /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner Washington Julia Manor Nursing Home Hagerstown If Under 24 Hrs. If Under 1 Year Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yeer) **Funeral** Months Days Hours 1 □ M 2 🗓 F Yrs 92 15 1913 April Maryland Director 214-09-0086 Usuel Residence of Decedent Pages 1 end 2 should be filed within 72 hours aftar death with the Marylend nant of Health end Mantel Hygiene. 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho 1 ☐ Yes 2 No Funeral Director Hagerstown Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number U.S.A. 11005 Roessner Avenue 21740 Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status 1 ☐ Yes 2 🕅 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: þ Year or Dates: 3 ☑ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Her own home 0 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be Carrie Evans David Brodie Bonney 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Health ( Hagerstown, Md. 21742 20712 Lebeck Drive Margaret Trader - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State ò **Depertment** 4 ☐ Donation 5 ☐ Other (Specify) 5/9/05 Harerstown, Maryland Rose Hill Cemetery 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be axecuted usa as the bunal-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Cunknown Completed by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes an eutopsy performed? 1 Tes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? edicai Certification: To Be 26. Place of Death (Check only one) Hospital: Other: Thursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Dey Yeer) 28d. Describe how injury occurred 1 Maturel 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours after To the Funeral Direcompletaly filled in b Hospital 124 hours 8 \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name end address of person who completed ceuse of deeth (Item 23e) (Type, Print) 3H-5 1126 Opal Court Khalid asestown 31. Dete filed (Month), Pay, 32. gegistrer's Signature State

**DHMH 16 Rev 6/95** 

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician Month Voor 4:15 AM MELBA LILLIAN CABIATI 05 18 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Heart Hospital Allegany Cumberland acred If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 🕱 F 220-05-7704 JULY 2, Director 1912 MARYLAND Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mudical Examinar must be nutilised at 1 Yes 2 No Director wv MINERAL. RIDGELEY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ROUTE 1, BOX 465 26753 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. should be filed within 72 hours after ond Mental Hygiene. 1 Tes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BOOKKEEPER & CLERK HOTEL 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (UNKNOWN) HARWARD LEONA IRENE FOWLER ္ဝ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Ia m any injury or other traum <u>once.</u> PATRICIA SHAY / DAUGHTER ROUTE 1, BOX 465, RIDGELEY, WV 26753 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) CUMBERLAND CREMATORY 05/19/2005 CUMBERLAND, MD 21. Signature of Funeral Service 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502 23a. Part 1. Enter the dile se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrorascular Accident **Physician** disease or condition resulting in death) DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ COVERNY AVERY diseAVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Hyperparathyraidism. 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 200 No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA P 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifie D54756 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Cumberland, Maryland 912 32. Regietrar's Signature 31. Date filed (Month, Day, Year) Registrar 2005

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

		For State Registrar	State of Marylan	d / Depa		ealth and	Mental Hy		0 0 5	1700
Physicia /Medic Examin	in al er	1. Decedent's Name (First, Middle, Last)  JOHN FULLERTON  4a. Facility Name (If not institution, give s  Salisbury Nursing a			4b. City, Town, or	Salisbu	ry, Md.	8. 4c. Cou	2005 nty of Death	3. Time of Death 3:55 A M
Funeral Director		-12 01 0012	7. Age (In yrs. 68	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		1936	9. Birthpla Countr MARYI	ace (State or Foreign y) AND
ING 21215-U036  be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show sevent, I'm Modical Examiter mant be muffind at	Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  DELAWARE  SUSSEX  10e. Street and Number  114 MARKET STRE  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade)  Elementary/Secondary (0-12)  12	ET  12. Was Decedent Ever in U. Armed Forces?  1  Yes, Give Year or Dates:	16a. Dece (Give life.		spanic Origin? ( n, Mexican, Pue Specify: ation turing most of w R	Specify Yes or No- nto Rican, etc.)	US 14. F Spe 16b. Kind of	of What Countr A Race - America Black, White, et cify: WHIT Business/Indu	n Indian, tc. I'E
Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once.	To Be	JOHN JOSEPH CAMPB  19a. Informant's Name/Relationship (Tyr.  SHIRLEY H. CAMPBE  20a. Method of Disposition  1   Burial   2 M Cremation   3   Re.  4   Donation   5   Other (Specify)  21. Signature of Funeral Service bicense	emoval from State  EASTI  BE MOO866	114 lace of Dispo emetery, crer TRN SHOR	MARKET ST. sition (Name of natory or other place E CREMATORI RELL FULL 2 LAWS ST.	KATHAR  And Number or F  FREET F  B  O  O  O  FREET H  O  FREET F  FREET F  FREET F  FREET F	RINE NELS  BRIDGEVIL  Date  1/2005  DMES, HAR  BRIDGEVIL	ON FUL  or, City or Tov  LE DE  20c. Locatic  LEWES O  DESTY  LE DE	LERTON  wn, State, Zip C  19933  on - City or Tow  DELAW  CHAPEL	3 /n, State ARE
S760,  Step be executed with the price of th	Ilcal Examiner	23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	uence of): uence of):	er the mode of dyin	g, such as cardio	ac or respiratory ar	rest,	7.	Approximate interval Between Onset and Death
Hecords, P.O. Box 68. The law requires that the death certificate the has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	in the past 12 months?  1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3 eath 5	Ectopic pregnancy Other (specify)		220 Did to			Day Year
of Vital Physician: rthis certifica	To Be Completed by	25. Was case referred to medical examiner?  1  Yes 2 No H	lospital: 1 Inpatient 2 28a. Date of Injury		nt 3□ DOA Othu	26. Place of Dr er: 4 Avursing	1 ☐ Y 24a. Was autop perfoi	rmed? 2 No ne) dence 6 0	b. Were autops prior to comp death? 1 Yes 2	sy findings available pletion of cause of
DIVISION tal or Attending rs after death. al Director: Afte ed in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, str y)		Yes 2 □ No	28f. Location (S City or Tow		mber or Rural I	Route Number,
To the Hospital or A within 24 hours after within 24 hours after to the Funeral Director Completely filled in by	Medical	(Check only 2 Medical Examinate)  29b. Signature and title of certifier  30. Name and address of person who completely medical Examination of the complete of		n 23a) (Type,	29c. License 29c. License 27 Print)	oinion, death occ	curred at the time, o	date and plac		he cause(s)
DHMH 17 Rev 1/20			MARILE	I A	pares)		-			

			State of Maryland / Department of Health and M  1- State State of Maryland / Department of Health and M  Certificate of Death		13 M 1 100	17001
			Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
	Physicia /Medic		Denver Evi Cooper	Month 05	Day 7 Year	5 0921 M
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Dea	•
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	O Data of Birdh	HICOM	
	Funeral Director		5. Social Security Number 6. Sex X Age (In yrs. last birthday) If Under 1 Year If Yider 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Pay, 3-5-34	Year) 9. Bir	thplace (State or Foreign ountry). W. Va.
	ס		Usual Residence of Decedent			
	arylar show	_	10a. State 10b. County 10c. City, Town or Location  De. Sussex Delmar			10d. Inside City Limits  XXYes 2 □ No
	28a-f	ecto	De. Sussex Delmar  10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	
	with 3a or	Funeral Director	206 N. 10th St. 19940	10	USA	Junity :
	ms 2:	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - Ame	
9	after or Ita	/ Fui	1 □ Never Married XX Married 1 XYes 2 □ No 1952 - 1 □ Yes 2 X No Specify:	nican, etc.)	Black, Whit	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show the Medical Examinet must be nutified at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1956		Specify: wh	
7	in 72 n "na	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of workir life. DO NOT use retired)	ng l'	6b. Kind of Business	rindustry
212	d with giene.	mo	Elementary/Secondary (0-12) College (1-4or 5+)  12 Owner	Н	eating & (	Cooling
nd	2 should be filed within and Mental Hygiene. Is markad othar than aumatic avant, If e M.	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name	(First, Middle, M	aiden Surname)	
Уlа	should be nd Mental markad matic av	٦	Donovan Cooper Zona Wya			
Maryland	d 2 st th and 7 is n traun		19a. Informant's Name/Relationship (Type, Print)  Esther Cooper, Wife  19b. Mailing Address (Street and Number or Rura  206 N. 10th St. Delma			Zip Code)
	Health tam 27 i		20a Method of Disposition 20b. Place of Disposition (Name of		0c. Location - City or	Town, State
altimore,	Pages nent of int: If it		1 XBurial 2 Cremation 3 Removal from State 1 A Donation 5 Other (Specify)  1 XBurial 2 Cremation 3 Removal from State 1 XBurial 2 Cremation 3 Removal from State 1 XBurial 2 Cremation 3 Removal from State 1 XBurial 2 Cremation 3 Removal from State 1 XBurial 2 Cremation 3 Removal from State 1 XBurial 2 Removal	10-05	Hebron, M	d.
alti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic avant, If a Medical Examinat must be nuffled at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home			
<u> </u>	82589		Ciny Ohort Quell 13 E. Grove St. De	1mar, De		
r	- 1		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.		st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Althoroscorotic Conoming Listed resulting in death)	my Di	SIGGE	
:	Examiner		Due to (of as a consequence of):  Palmonary Embolus			
		Jer	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):			
	acuted nd transii	Examlner	cause. Enter Underlying Cause (Disease or injury that initiated events C.			
8760,	icate be executed physician and s the burial-transit	EX	resulting in death) Last  Due to (or as a consequence of):			
687	physi s the b	dlce	d			
Box (	death certificate be executed e attending physician and id for use as the burial-transit	Physiclan/Medlcal	IF FEMALE: 23b. Was decedent pregnant  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de	livery
O. B		sicla	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
P.	that the dened by the a	Phy	9 Li Unknown	220 Did toba	usas usa efeatebuta te	o the cause of death?
ds,	88 25 0	d by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 ☐ Yes		robably 4 Dunknown
COL	w require been si should b	letec		24a. Was an	24h Were au	utopsy findings available
Vital Records,	The lay	Completed		autopsy performe	ed? prior to death?	completion of cause of
ita	ician: Th certificate rector, pag	Be C	25. Was case referred to medical 26. Place of Death			2 No
	Physician: this certific	To		ne 5 🗆 Residen	ce 6 □Other (Spe	cify)
o uc	ding P. h. After t funera	ion:	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work?	.8d. Describe how	v injury occurred	
Division of	l or Attanding after death. Diractor: After in by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 2	8f. Location (Stre	eet and Number or Ri	ural Route Number
2	al or A after I Dirac d in by	Certification:	4 Homicide determined 256. Place of Injury Actionie, family Street, factory, office building, etc. (Specify)	City or Town,	State)	
	spita nours nara / fille	edical C	29a. Certifier (Check only (Check only 1) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	and due to the cau	ise(s) and manner as	stated.
	0 - 3 -	.=	one) and manner stated.	d at the time, dat	e and place, and due	(o the cause(s)
	tha Ho nin 24 i tha Fu npletely	Med	00-15	00		1 D. V.
	To tha Hospital or Attanding Physician: The within 24 hours after death.  To tha Funaral Diractor: After this certificate his completely filled in by the funeral director, page	Med	29b. Signature and title of certifier  29c. License number	290	d. Date signed (Mont.	h, Day, Year)
)	To the Ho within 24 i To the Fu completely	Med	D54127	290	d. Date signed (Mont	h, Day, Year)
•	VA within 24 in To tha Ho within 24 in To tha Full Completely	Med			5/7/ 5/7/	h, Day, Year)
	Hedistrict to the House Hedistrict S41 States Full Completely	₩ te	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		5 / 7 / (	h, Day, Year)

			1 – For State Registrar	State of Marylan	-	artment of H			giene ag. No. 2005 17232
	Dhyciai	20	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ath 3. Time of Death Day Yeer
	Physici /Medic		Olga Stevens					May	2 2005 7:05 A M
	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town, or			4c. County of Death
			9102 Ridgewood 5. Social Security Number 6. Sex		last hirthday)	Ft.	Washi		Prince George's
	Funeral Director			144 0377 5	75 Yrs.	Months Days		Min. (Month, Day Aug • 13.	v, Year) Country)
	Ţ.		Usual Residence of Decedent					11449-19	
	show	-	10a. State 10b. County	10c, City	y, Town or Lo	cation			10d. fnside City Limits 1 [XYes 2 □ No
	Aga-f	Director	Maryland Prince	George's		10f. Zip Code	t. Was	hington	10g. Citizen of What Country?
	with with	Dir	9102 Ridgewoo	od Drivo		Tot. Zip Code	20744		United States
	ms 23	Funeral		12. Was Decedent Ever in U.	S. 13.	Was Decedent of H		? (Specify Yes or No- uerto Rican, etc.)	
9	or Ite	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		it Yes, specify Cuba 1 □ Yes 2 □XNo	in, Mexican, P Specify:	ueπo Rican, etc.)	
003	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show disal Examinetr and be redified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:					27401
21215-0036	a within 72 hours after death with the Marylan Jiene. r than "naturel", or Items 23e or 28a-1 show The Modical Examiner out the multiful at	Completed	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occupa kind of work done o DO NOT use retired	durina most of	working	16b. Kind of Business/Industry
12	within iene.	ошр	Elementary/Secondary (0-12)	College (1-4or 5+)		Cash			Private
þí	il Hygir other vant, II	BeC	17. Father's Name (First, Middle, Last)			OGSI		Name (First, Middle,	
/lar	2 should be and Mental Is marked o	To E	Henry Ste	venson				Elizab	oeth Brooms
Maryland	2 sho and I s ma		19a. Informant's Name/Relationship (Ty		1				r, City or Town, State, Zip Code)
	ges 1 and 2 should be filed it of Health and Mental Hyg If item 27 Is marked othe or other traumatic evant,		Dr. Ian M. Doug			018 Rhode	Islan	d Ave., N.	E. Wash., DC 20018  20c. Location - City or Town, State
Baltimore,	in of h		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	emetery, crei	natory or other plac		- 1	
Iţi	permit. Pages Department of H Important: If ite any Injury or of		'4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	, eq.		Crematory  2. Name and Address		A	Clinton, MD Funeral Home
Ba	permi Depa Impo any I		1 State T St	antait III					Vash., DC 20019
	-		23a. Part 1. Elyter the disease, or complishock on heart failure. List only or	cations that caused the death	h. Do not ent				
	Pnysician :	, u	Immediate Cause (Final disease or condition	Sepri	0				Onset and Death
	/Medical Examiner		resufting in death)	Due to (or as a conseq	uence of):		541 T210		
	Examiner	٠.	Sequentially list conditions,	Due to (or as a conseq	yolog	annes J	Janko	mia	
	led sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enier Underlying Cause (Disease or injury	Due to (or as a conseq	Dance of):	7			
	execution and al-train	Examine	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):				
8760,	death certificate be executed e attending physician and ed for use as the burial-transit	cail		d.					
9	ntifical	Physician/Medicai	fF FEMALE:						
Вох	eath certific attending p for use as f	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta	death 3	Ectopic pregnancy	,		23d. Date of delivery  Month Day Year
0	the a	ysic	1 Yes 2 No	4☐ Pregnant at time of d	eath 5	Other (specify)			
σ.	that the de led by the a detached		Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use contribute to the cause of death?
Records,	Se PB	d by						1 □ Y	es 2 No 3 Probably 4 Unknown
CO	law require as been si 2 should t	ompleted						24a. Was	
Re	lhe age	mo:				····		— autop perfor 1 ☐ Yes	prior to completion of cause of death?  2 🖫 No 1 🗆 Yes 2 🗀 No
Vital	ician: T certificat rector, p	Be C	25. Was case referred to medical examiner?					Death (Check only o	ne)
of V	Physician: this certific ral director,	2	1 Yes 2 No		ER/Outpatie				dence 6 ☐ Other (Specify)
		lon:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Worl	yat k? Yes 2 ∐No	28d. Describe n	now injury occurred
Division	tand leath tor: the	Certification;	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome, farm, st		165 2 110	28f. Location (S	Street and Number or Rural Route Number,
$\overline{0}$	after Dira	erti	4 Homicide	building, etc. (Specif	y)	, , , , , , , , , , , , , , , , , , , ,		City or Tow	vn, State)
	To the Hospital or At within 24 hours after d To the Funeral Diract completely filled in by	edical C							cause(s) and manner as stated. date and place, and due to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier	1		29c. Licens	e number		29d. Date signed (Month, Day, Year)
}			Dragon	nkersk		17	2660	1	5/4/05
0	(2)		30. Name and address of person who co	ompleted cause of death (Item	n 23a) (Type,	Print)		*	
	(A)		Craig M			00 Reserv	oir Rd	., N.W. Wa	ash., DC 20007-2197
	Sta Registi		31. Date filed (Month, Day, Year)  MAY 9 9 2005	32 Registrar's Signa	ture do	We .			

		1 - For State Registrar		partment of Health and Nertificate of Death	lental Hygier	2005 17233
Dhuoi	ion	Decedent's Name (First, Middle, La	· ·		Date of Death     Month	Day Year 3. Time of Death
Physic /Med		THELMA	L. DUCKETT			2005 2:50 PMM
Exami		4a. Facility Name (If not institution, gire	ve street and number)	4b. City, Town, or Location of Death		4c. County of Death
		Ginger Cove Heal	th Center	Annapolis		Anne Arundel
Funera		5. Social Security Number 6.	Sex 7. Age (In yrs. last birthda	Months Davs Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birthplace (State or Foreign Country)
Director		218–28–0140 Usual Residence of Decedent	95 TIS		May 2, 1	910 Maryland
land		10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
Mary 18th	ţō	7 Anno A	rundel Annapo	alie		1 ☐ Yes 2∑ No
1 the	rec	Maryland Anne A 10e. Street and Number	<u>umaer</u> ranape	10f. Zip Code	10g.	Citizen of What Country?
3a o	O TE	3212 River Creso	ent Drive	21401	Un	ited States
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28e-f show other treumatic event. In Medical Evertination in Item 21.	Funeral Director	11. Marital Status		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian,
after or Ita	Ē	1 Never Married 2 Married	1 ☐ Yes 2 <b>XX</b> 0 If Yes, Give	1 Yes 2 No Specify:	rican, etc.)	Black, White, etc.
ral,	l by	3 Widowed 4 □ Divorced	Year or Dates:	1 163 2 Age Specify.		Specify: white
72 h natu	Completed	15. Decedent's E (Specify only highest gr	ade completed) (G	cedent's Usual Occupation ive kind of work done during most of work	ing 16b	. Kind of Business/Industry
nthin nen Me	du	Elementary/Secondary (0-12)	College (1-4or 5+)	e. DO NOT use retired)		
led w lygier har t		17. Father's Name (First, Middle, Las	41	homemaker	e (First, Middle, Maid	own home
buld be filed with Mental Hygiene arked othar tha atic evant, the	Be		_			ien Sumame)
should I	ပို	Thomas Oscar L		Augus La ailing Address (Street and Number or Rur	a Faust	trues Tours State Zin Code)
12 sho h and 7 la m		19a. Informant's Name/Relationship		)2 Lloyd Court Anna		
permit. Pages 1 and 2 Department of Health a Importent: If itam 27 I. any injury or other tra once.		Barbara D. Hille 20a. Method of Disposition	20b. Place of Dis	sposition (Name of		Location - City or Town, State
Pages nent of ent: If it ary or o		1 Surial 2 Cremation 3	Hemoval from State	crematory or other place)		
it. Purtine		4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice		nt Cemetery   5-6-		vidsonville, MD or Funeral Home, Inc
Departition Departition Departition Departition Departition Departition Departition Department Depa		21. Syllature of Purioral Selfice Lite		147 Duke of Glouces		
Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Gasts in le Due to (or as a consequence of):	enter the mode of dying, such as cardiac Symal CANCEN		Approximate Interval Batween Onset and Death
te be executed ysician and e burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underthing Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consequence of):  Due to (or as a consequence of):			
The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3 ☐Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
quires tha an signed uld be de	þ	Part II. Other significant conditions	contributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?  2 No 3 Probably 4 Unknown
The lar	Completed				24a. Was an autopsy performed 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
sicia: certif rector	Be	25. Was case referred to medical examiner?	Hospital:		h (Check only one)	- Tour 16
Phys this al dii	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Outpa  28a. Date of Injury 28b. Time	tient 3 DOA 442 Nursing Ho	me 5 Residence 28d. Describe how in	6 ☐ Other (Specify)
ding After fune	fon	1 Natural 5 ☐ Pending	(Month, Day Year) Injur	y Work? M 1 ☐ Yes 2 ☐ No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certifica completely filled in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not determined	be as Bless of laws. At home form		28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
file file			hysician: To the best of my knowledge, di iminer: On the basis of examination and/o and manner stated.		red at the time, date	
n 24 ho n 24 ho ha Fun sletely	edica	one)				
To the Hospital or At within 24 hours after d Volta Buns all Direct Completely filled in by	Medical		1	29c. License number		Date signed (Month, Day, Year)
To the Hos within 24 hr To the Fun completely	Medica	one)	oh	29c. License number 0 2474 8		
To the Hos within 24 h To the Fun completely	Medica	29b. Signature and title of certifier	ocompleted cause of death (Item 23a) (Tyl)	D24748	5	Date signed (Month, Day, Year)

		1	For State Registrar	State of	Maryland /		artmen tificate			ınd M	ental Hy	/giene Reg. No.	00	5	172	34
	Dhuaisia		1. Decedent's Name (First, Middle								2. Date of D Month	Day	Y	эаг	3. Time of D	Death
	Physicia /Medic	al -	James	Warren		Dean					May 6,				5:30 A	М
	Examin	er	4a. Facility Name (If not institution						Location o	f Death			County of			
			Southern Maryland			binb de ci	Clint		If Under 2	24 Hre	8. Date of B		nce Ge			
	Funeral Director		5. Social Security Number 578–38–5349	6. Sex 7.	. Age (In yrs. last 77	Yrs.	Months	Days	Hours	Min.	(Month, D	ay, Year)	27 [4]	Coun	lace (State or try) ngton, [	roreign
		-	Usual Residence of Decedent						ll	4	ctober	20, 19	21   14	аыш	ngcon, 1	<i>7.</i> C.
	yland		10a. State 10b. County		10c. City, To									1	0d. Inside City	/ Limits
	a-fs	to	Maryland Prince	÷eorge's	Uppe	er Mar	Tboro								1 🗌 Yes X	2\(\)(No
	or 28.	ire	10e. Street and Number				10f. Zip	Code				-	zen of Wha	t Cour	try?	
	23a	Funeral Director	9805 Healy Court				2	0772				U	SA			
	r dea	nei	11. Marital Status	Armed Force		13. V	Was Deced	ent of Hi	ispanic Orig in, Mexican	gin? (Spe , Puerto l	cify Yes or N Rican, etc.)	0-	14. Race - Black, 1			
36	s afte	by Fu	1 ☐ Never Married 2 🔀 Marr 3 ☐ Widowed 4 ☐ Divorced				1 ☐ Yes	2KX No	Specify:				Specify:	Mhi +	0	
8	filed within 72 hours after death with the Maryland Hygiene ther than "natural", or Items 23a or 28a-f show ther than "natural", or Items Leandlin of at	g b	15. Decedent			6a Decer	ient's Usua	I Occup	etion				nd of Busin			
쟌	n 72	Completed	(Specify only highes	t grade completed)		(Give	kind of wo	rk doné d	during most	of worki	ng	TOD. KI	10 01 00311	033/1110	addity	
72	with iene. r thar	mo	Elementary/Secondary (0-12)	2 years	tor 5+)	Loan S	upervi	sor				Fede	ral Go	vern	ment	
D	filed Hyg other	e C	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middl	e, Maiden	Sumame)			
lar	uld be Aenta rkad tic ev	To Be	Spencer Dean						Syb	il Ha	11					
Maryland 21215-0036	2 sho and h is ma		19a. Informant's Name/Relations								I Route Num		_	te, Zip	Code)	
Σ.	and and m 27 m 27 nar tra	].	Helen C. Dean / W	LIE					Clinto	4440		2073		_		
ore	Jes 1 of H If itel		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from St	ceme	etery, cren	sition (Nar natory or o	ther plac	-		ate		cation - Cit			
Ē	Pag tment tant; jury		`4 ☐ Donation 5 ☐ Other (S	pecify)	Resur						, 2005	Clin	ton, M	aryl	and	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amount in jury or other traumatic event, the Neulcul Eventil at man ke inclined at once.		21. Signature Funeral Service	Valop	7	646	6160 C	xon F		oed Ox	rge P. on Hill	, Mary				
г			23a. Part1. Enter the disease, or shock, or heart failure. List	complications hat car only one cause on ea	used the death. E ch line.	o not ent	er the mod	e of dyin	g, such as	cardiac o	r respiratory	arrest,			Approximate Interval Betw	reen
	Physician <sup>*</sup>		Immediate Cause (Final disease or condition	a Arter	iosclerotic	c Card	liovaso	cular	Diseas	se					Onset and Do	Batti
	/Medical Examiner		resulting in death)	Due to (o	r as a consequen	ce of):										
Н	_xammor	_	Sequentially list conditions.	b	r as a consequen-	ce off:								-		-
	led nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	50 00 (0	as a consequent	co oi).										
	xecu and	Examiner	that initiated events resulting in death) Last	c. Due to (o	r as a consequen	ce of):								=		
8760,	icate be executed physician and s the burial-transit	cai		d												
9	tificat g phy as th	ledi			1277		11-21-2									
Вох	death certific e attending p d for use as 1	M/u	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy th 2 Tetal de		Ectopic pr	ednancy				1	23d. Date o		*	
	deat ed for	Physician/Medical	in the past 12 months? 1 Yes 2 No		nt at time of death		Other (sp						Month		Day Ye	еаг
P.0	that the de led by the a detached t	Phy	9 Unknown			4. 44			1.0.1		ana Did	l tabassa u		to to th	a souss of do	
-	es gu	þ	Part II. Other significant condition  Encephalopathy	•	ith but not resultin	ig in the ui	nderlying c	ause givi	en in Paπ i.			Yes 2XI			ne cause of de ably 4 □Ur	
orc	w requires been sign should be	eted											T		1,772	
Vital Records,	B 55 CA	Completed									24a. Wa aut	s an opsy formed?	24b. We prio dea	r to co	psy findings a npletion of ca	vailable use of
a											1 ☐ Yes	<b>≫</b> No	1 🗆	Yes	2 No	
Zit.	Physician: this certific ral director,	Be	25. Was case referred to medica examiner?	Hospital:		(0		Cth	0.00		(Check only			· · · ·	1	
o		.: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of	Injury 28	b. Time of	it 3 DC	8c. Injun	v at		ne 5 🗆 Res 28d. Describe			<i>эрөсп</i>	/)	
on	Attanding Ph r death. ector: After th by the funeral	tio	1 XNatural 5 ☐ Pendir 2 ☐ Accident investi	g .	, Day Year)	Injury	М	Wor! 1 □	k? Yes 2⊡l	No						
Division	l or Attandatter death Director: in by the	iffica	3 Suicide 6 Could determ	not be ined 28e. Place of	of Injury - At home g, etc. (Specify)	, farm, str	eet, factor	, office		:		(Street an		or Rura	l Route Numb	ier,
Ö	spital or At ours after o neral Direc filled in by	Certification:	4   Nomicide	Building	g, etc. ( <i>Specify</i> )						Oily or 7	own, otato				
	는 무료 이	edicai		g Physician: To the be Exeminer: On the bas and manner	sis of examination											
	To the Hos within 24 ho To the Fun completely	Mec	29b. Signature and title of certifie		31 3(4)(04)		290	c. Licens	e number						Day, Year)	
	- st o		· MOT				and the state of t	D 1	1.8545			May	6, 20	05		
P	R - 6		30. Name and address of person	who completed cause	of death (Item 23	Ba) (Type,	Print)									
	1		P. Wisotsky		Old Line Co		Waldor	f, Me	aryland	1 20	602					
	Sta		31. Date filed (Month, Day, Year)	05 232. Re	gistrar's Signature	hour	g,									
	Regist	ar	MAY 1 0 20	- Julies	7	1										

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2005 Month MAY **Physician** LINDA DAVIS DULIN 4 12:10 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner MONTGOMERY** NATIONAL NAVAL MEDICAL CENTER BETHESDA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 3, 1945 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗗 Months Days Hours Min. Tennessee Yrs. 220-46-8317 60 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show 10a. State the Medical Examiner must be notified at Vienna 1 Yes 2 No Virginia Fairfax Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6 22181 2575 Plum Tree Court USA Ітетв 23а death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: þ 3 Widowed 4 Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Importent: If item 27 is marked other than any initing on other treumatic event, the Magnetic Conce. Elementary/Secondary (0-12) College (1-4or 5+) 3 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Davis Catherine Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>James Dulin/Spouse</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 5/5/05 Alexandria, Va. `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FUNERAL HOME, INC. chara 171 W. Maple Ave., Vienna, Va. 22180 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician NON SMALL CELL LUNG CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine transit. The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): as the burial P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ☐ Yes 2 ☐XNo detached 9 Unknown been signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause ol death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 2 XNo 1 Yes To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 🔀 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) <sup>o</sup> 1 ☐ Yes 2 🛣 No 2 ER/Outpatient 3 DOA completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 1 XXX tural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Thomicide 29a, Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 2005 **RES-000** 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 LAWRENCE OSEI 31. Date liled (Month, Day, Year) 2. Registrar's Signature State Registrar 0 6 2005 MAY

		1 - State Registrar  1. Decedent's Name (First, Middle, L	State of Marylar		cate of D			eg. No.20	05	1723
nysicia Medic xamino	ai	Patricia K. Dor: 4a. Facility Name (If not institution, gi Atlantic General	sch ve street and number)		City, Town, or Lo	ocation of Death	Month May 5	Day 200.		7:23 P
neral ector			Sex 7. Age (In yrs. 1 M 2 X 66			f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 3 1	Year) 939	9. Birthpla Counti Smack	ace (State or Fore y) Kover, Al
Illied at	Director	10a. State 10b. County  Delaware New Cas		ty, Town or Location	ו				10	d. Inside City Limi
then		10e. Street and Number 413 Delaware Ave	anua		f. Zip Code 19803			0g. Citizen of V		•
Examinarions	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	.S. 13. Was I	ecedent of Hisp specify Cuban,	anic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Blac	e - America k, White, et White	n Indian, tc.
na Mactical I	Completed	15. Decedent's Elementary/Secondary (0-12)		16a. Decedent's (Give kind life. DO N	of work done dur OT use retired)	ing most of work	ing	16b. Kind of Bu		stry
tic event, I	To Be Co	17. Father's Name (First, Middle, Las  F. Wayne Keeley	t)	1331314	18	3. Mother's Name	R. Cros	faiden Sumam		
her trauma		19a. Informant's Name/Relationship Barry W. Dorsch	(husband)	413 De	Laware A	venue,	al Route Number, <b>Wilmingt</b>	on, DE	19803	
any injury or other traumatic event, the Medical Executrier cuted be nutified at once.		20a. Method of Disposition  15 Burial 2 □ Cremation 3 □  14 □ Donation 5 □ Other (Special Control of Special Control of Control of Special Control of Control of Con	Removal from State		Church  e and Address	Cem. of Facility Ch.	ay 12,		ton, Homes	DE
	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Erier Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseq c. Due to (or as a conseq d.	uence of):	EPĪL 447	TON			- Fen	Onset and Death
detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	I death 3 Ector	oic pregnancy r (specify)			23d. Date Mor	of delivery	ay Year
8 .	2	Part II. Other significant conditions	contributing to death but not res	ulting in the underly	ing cause given i	n Part I.				cause of death?
	Completed						24a. Was an autopsy perform	ed? d	Vere autops rior to comp eath?	y findings available of cause of
direct	o Be	25. Was case referred to medical examiner?  1° ✓ Yes 2 □ No	Hospital: 1 Inpatient 2 19	ER/Outpatient 3	011		n <i>(Check only one</i> me 5 ☐ Resider		- (Cit-)	
lera ,	Certification: 1	27. Manner of Death  1 PNatural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes		28d. Describe hov			
		4 Homicide determined	building, etc. (Specify	v)			28f. Location (Streetly or Town,	State)		
oletely .	Medical	(Check only one)	nysician: To the best of my kno miner: On the basis of examina and manner stated.	tion and/or investiga	rred at the time, i ttion, in my opini	on, death occurr	and due to the car ed at the time, da	use(s) and mar te and place, a	ner as state nd due to th	ed. e cause(s)
disco			Lweth M. S.		29c. License nu \$ 06_		29	d. Date signed		y, Year)
	1	30. Name and address of person who	completed cause of death (Item	23a) (Type, Print)						

DHMH 17 Rev 1/2001

)ORCEY,

				State of Maryland / L	Certificate of		ygiene 05 17238 Reg. No.
	Physic	ian	1. Decedent's Name (First, Middle, Las. Esfir	n DUBINSKAYA		2. Dete of Detection Month	Deeth 3. Time of Death  Poeth Year (2-20 AM)
	/Medi Exami		4a Fecility Neme (If not institution, give Layhill Cente		4	tb. City, Town, or Location of Des Silver Spring	
	Funeral Director		Social Security Number 6. Se	7. Age (In yrs. last bir	rthday) If Under 1 Year  Yrs. Months Deys	If Under 24 Hrs. Hours Min.  8. Date of E	Sirth 9. Birthplace (State or Foreign Country) 26, 1913 Ukraine
	bud wo		Usuel Residence of Decedent  10a. Stete 10b. County	10c. City, Tow	n or Location		10d. Inside City Limits
	a-fah	ctor	MD Montgomer	y Tako	ma Park .		¥El Yes 2□No
	th with the 23e or 28 ust be no	al Dire	10e. Street end Number 7620 Maple Ave. #3	01	10f. Zip Code 20912	2	10g. Citizen of What Country? UKRAINE
920	permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Depertment of Health and Meniel Plyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show important; or other traumatic event, the Medical Examinar must be notified at ADMS.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Merried  3 Vidowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:	13. Was Decedent of H if Yes, specify Cuba  1 □ Yes 2 □	lispenic Origin? (Specify Yes or t an, Mexican, Puerto Rican, etc.) Specify:	14. Race - American Indian, Black, White, etc.  Specify: White
15-0	"natur	leted	15. Decedent's Edu (Specify only highest gred	ucetion 16a. de completed)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	etion during most of working	16b. Kind of Business/Industry
212	d withir jiene. r then	dmo	Elementery/Secondary (0-12)	College (1-4or 5+)	Homemaker	,,	Own Home
pu	be filed tel Hyg d othe	Be	17. Father's Neme (First, Middle, Last) Srul Leshch	iner		18. Mother's Name (First, Midd Rosa Kamin	
ıryla	should nd Men merke	2	19a. Informant's Name/Relationship (T)		o. Mailing Address (Street		nber, City or Town, State, Zip Code)
, Ma	elth er		Mark Dubinskiy /			Garden Way, Oln	
Baltimore, Maryland 21215-0036	Peges 1 (ment of He ment: if Item ury or other	b	20a. Method of Disposition 1 ABurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify,	Removal from State	of Disposition (Name of try, crematory or other place of Memorial Ga	arden May 10,	20c. Location - City or Town, State 2005 Olney, MD
Balt	permit. Depentingort any inj		21. Signature of Funeral Savice Licens	2,C	254 Carro	ll St., NW, Was	y Hebrew Funeral Home hington, DC 20012
	Physician /Medical Examiner	er	23a. Pert1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	· Cerebra		rg, such es cerdiac or respiratory	Oliset and Death
ox 68760,	lew requires that the death certificate be executed tes been signed by the ettending physician and 2 should be deteched for use as the buriel-transit	VMedical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Lest	С.	consequence of):		
Box	deeth e etter ed for t	Physician/N	Pert II. Other significant conditions co	intributing to deeth but not resulting i	n the undertying cause giv	ren in Part I. 23b. Di	d tobacco use contribute to the cause of death?
, P.O	thet the ned by the deteche	by Phy				1[	Yes 2□ No 3□ Probably 4½ Unknown
of Vital Records,	ew requires thet the deeth cer ss been signed by the ettendin 2 should be deteched for use	Completed b					as an autopsy findings available prior to completion of cause of death?
E E	The ete h pege					- 40	JYes 2KNU 1 ☐ Yes 2KNo
Vita	Physician: The this certificate ral director, peg	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	utpatient 3 DOA Oth	26. Place of Death (Check online):	y one) sidence 6 □Other (Specify)
	Attending Physic death.  •ctor: After this by the funeral d	ation: To	27. Menner of Deeth  1 XNaturel 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Dey Year) 28b.	Time of 28c. Injur	v et 28d. Describ	e how injury occurred
Division	al or Atter s efter des i Director d in by th	Sertific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office		(Street and Number or Rurel Route Number, rown, State)
X	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: Affer th completely filled in by the funeral	edical Certification:		vsician: To the best of my knowledge iner: On the besis of examination en and menner stated.			e cause(s) and manner as steted. e, date and place, and due to the cause(s)
)	To the To the comp	M	29b. Signature and title of certifier	Ducking Dhy -	Sucan 29c. Licens	53642	29d. Date signed (Month, Dey, Year) Hay 9 2065
	'		30. Name and eddress of person who co	5601 Loc	(Type, Print)  Kalaki	B(UD 30	3 Baltimone 21239
	St Regist	ate rar	31. Dete filed (Month, Dey, Year)  MAY 1 0 20	35 Régistrer's Signature	Boule		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day May Elenore Elliott 2005 3:08 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood of Williamsport Williamsport Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2፟MF 95 Yrs Director 219-68-1167 August 7,1909 Maryland Usual Residence of Decedent death with the Maryland 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits or 28a-f show traumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Ave. 21795 U.S.A. or itema 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 戶 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Itam 27 Is markad other than "natural", or Itel 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Gladhill Melinda Eyerly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Calista J. Richardson/Daughter 249 Daycotah Ave Hagerstown Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🕅 Burial 2 □ Cremation 3 □ Removal from State ö permit. Page Department of Important: If any injury or once. Rest Haven Cemetery May 11,2005 Maryland, Hagerstown `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Euneral Service Licensee 1601 Pennsylvania Ave Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. signed by the a 1 Yes 2 No 9 Unknown Part IJ, Other significant conditions, contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2. No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 📉 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) ompleted cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

			For State Registrar	State	of Mar	yland / D	-			ealth a Death			giene Reg. No.)	105	1 *** (**	
			1. Decedent's Name (First, Middle	e, Last)								2. Date of De	ath Day	Year	3. Time of	Death
	Physici /Medio		Beatrice T	. Ellifi	ritz							May 11			7:05	р <sup>м</sup>
	Examin		4a. Facility Name (If not institution	n, give street and n	umber)		4	b. City, T	own, or	Location	of Death		4c. Coi	inty of Deat	h	
			Dennett Rd.	Manor Nu	anor Nursing Home			Oak	lan	đ.			Ga	rrett		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ᡚ F	7. Age (	In yrs. last birt	Months   Davs   Hours   Min.					8. Date of Bir (Month, Da	th ly, Year)	9. Birt Co	hplace (State or untry)	r Foreign
	Director		220 52 9683	1 M 2 X	107	7	Yrs.					Sept 1	8 189	7 Ire	land	
	pue 🔧 📑		Usual Residence of Decedent  10a. State 10b. County		1	Oc. City, Town	or Loca	tion							10d. Inside Cit	ty Limits
	Aaryli sho	ō					_								1 <b>∱</b> Yes	2 🗌 No
	28a-	Director	MD Garre  10e. Street and Number	tt		_Oakla	and	10f. Zip 0	Code				10g. Citizen	of What Co	untry?	
	with a or	ق											-			
	Jeath	Funeral	1100 Mary Dr.  11. Marital Status 12. Was Decedent Ever			er in U.S.	21550  3. Vas Decedent of Hispanic Origin? (Sp.					pecify Yes or No- 14. Race -			ncan Indian,	
•	r Iter	臣	1 ☐ Never Married 2 ☐ Mar	ried 1 ☐ Yes	2 ₽ No		lf Y	es, specif	fy Cubar	n, Mexicar	n, Puerto F	Rican, etc.)		Black, White		
<u> </u>	urs a	by	3 Widowed 4 ☐ Divorced	If Yes (	ive		1	Yes 2	No No	Specify:			Sp	<sup>ecify:</sup> Whi	te	
2	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show tha Madical Expirit at trust Lexi culting at	Completed	15. Deceden	it's Education	()	16a.		nt's Usual			t of working	na	16b. Kind	of Business/	Industry	
2	thin .	npie	Elementary/Secondary (0-12)	1	(1-4or 5+)		life. DO	NOT use	retired)	,g		.9				
2	ygien ygien yer th	S	8			Hc	ousel	keepi	ng					maker		
ב	be fill H d out	Be	17. Father's Name (First, Middle,	Last)						18. Mothe	er's Name	(First, Middle	, Maiden Sui	name)		
<u>\{ \} \</u>	ould Men Marke	ပ	Patrick Neary									Nicho.				
<u>a</u>	2 sh and is m		19a. Informant's Name/Relations			196.						l Route Numb		_	(ip Code)	
Baltimore, Maryland 21215-0036	and Health in 27 her t		David A. Burd	ock		20b. Place of		30x 5		Kıtz		er, MD	2153		Town, State	
0	ges toff fite	1 3	20a. Method of Disposition 1 1 Burial 2 ☐ Cremation	3 □Removal from	n State		y, crema	tory or oth	ner place		5/14/					
<b>E</b>	tmen tmen tant:		`4 □Donation 5 □Other (S			1001				1			Elk G		, WV V	
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depriment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event. The Madical Experimet must be callified at once.		21. Signature of Funeral Service	Licensee	100	·h	710	Chu	rch	St.	y Dav: Kit:	id A. I zmille:	Burdoc c, MD	k FH 21538		
			23a. Part1. Enter the disease, or spock, or heart failure. List Immediate Cause (Final	r complications that only one cause on	caused the	ne death. Do r	not enter	the mode	of dying	, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Betw Onset and D	ween
Ï	Physician /Medical		disease or condition resulting in death)	a		nani-		n							3 wee	Fi
	Examiner	- 5		Due to		consequence of		57	hi	1.	onse	+			5	-
		ē	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury	b. — Due to		conse uence			nı	10	C 70,0				1	f
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	6												
oʻ.	exec an an rial-tr	Exa	resulting in death) Last		o (or as a	consequence	of):									
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical		d										_		
39	ng ph	Med	IF FEMALE:	1					-	-						
Box	ath ce ttendi	an/l	23b. Was decedent pregnant in the past 12 months?		birth 2	Fetal death		ctopic pre					23d.	Date of del Month		rear
Ö.	the a	/sici	1 ☐ Yes 2 5 No 9 ☐ Unknown	4□Pre 9□ Unk		me of death	5 □ C	Other (spe	cify)						,	
P. O.	that the death certific ed by the attending p detached for use as		Part II. Other significant conditi	ons contributing to	death but	not resulting in	the und	erlying ca	use give	n in Part I		23e. Did t	obacco use	contribute to	the cause of de	eath?
ds,	w requires that s been signed t should be deta	d by	atheros	clero toc	- 0	-ordou	VES	Cyler	- (	Lise	ese	1 🗆	Yes 2 N	o 3 □ Pr	obably 4 🗆 U	Inknown
ŏ	requ been shoul	ete	cerebro			dis						24a. Was	20 2	th Ware au	topsy findings a	available
š	has has ge 2 s	Completed	- CEVEN YO	00304	UV	ars	663	10				auto		prior to death?	completion of ca	ause of
a	sician: The lav certificate has rector, page 2		05 Man ages referred to modical								-4 D4b	1 Yes	2)25 No	1 🗆 Yes	2□ No	
<b>=</b>	Physician: r this certifica ral director,	Be	25. Was case referred to medica examiner?	Hospital:	7 In nations	2 🗆 ER/Ou	tnations	- 2 - DO	Othe	-77		<i>(Check only o</i> ne 5 ☐ Resi		Othor (Can	16.0	
o	Phys r this ral di	.: To	1 ☐ Yes 2 No 27. Manner of Death		Inpatient e of Injury onth, Day		ipatient Time of		c. Injury	at		ne 5 ☐ Resi 28d. Describe			эну)	
O	ding th. : Afte	ţi	1 Natural 5 Pendii 2 Accident investi	ng (Mo igation	onth, Day Y	Year) li	njury	М	Work 1 🗀 ۱	:? ∕es 2. 🗆	No					
Division of Vital Records,	i or Attending after death. Director: After in by the funer	Certification;	3 Suicide 6 Could 4 Homicide	nined 286. Pla	ce of Injury	y - At home, fa	rm, stree	t, factory,	office	25-0	2	28f. Location ( City or To		umber or Ru	ral Route Numi	ber,
	tal or A s after al Direct ed in by	Cert	4 _ Homoleo	541	airig, oto.	(0)00.77										
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical		ng Physician: To t Examiner: On the		xamination an										)
	o the ithin i	Mec	29b. Signature and title of certifis		state			29c.	License	number			29d. Date si	gned (Monti	n, Day, Year)	
	⊢≯⊢ŏ		> alali	111.		٨	10		00	0 2	57	59	Moy 11	,20	5	
n			30. Name and address of person	who completed ca	use of des	ath (Item 23a)	Type. Pr	int)	-				T	,		
XX			walter K.	Naum		MD	PU	B	Oχ	24	7.	Accid	ent	MD.	21520	0
	Sta Regist		31. Date filed (Month, Day, Year	2 2005	Registrar'	's Signature	San	adi)			·					

		1 - State Registrar	State of Maryland	-	artment of tificate of			Reg. N	2000	1724
Physicia		Decedent's Name (First, Middle, Last)     VICTOR	E. EDWAR	פתכ			"	Date of Death Month D  MAY 4	ay Year 2005	3. Time of Death  12:06 A M
/Medic Examin		4a. Facility Name (If not institution, give st		מש	4b. City, Town,	or Location of			c. County of Dea	
		PRINCE GEORGES G	ENERAL HOSPIT	'AL		VERLY			PRINCE G	GEORGES
Funeral Director		5. Social Security Number 132-54-3791  Usual Residence of Decedent	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days		Min, (	Date of Birth Month, Day, Yea RCH 26,	9. Bir 1961 N	thplace (State or Foreigr ountry) IEW YORK
land ow		10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City Limits
filed within 72 hours after death with the Maryland Hygiene. ther than "neturel; or items 23e or 28e-1 show ant, the Masilcal Exactiner must be natified a	tor	MD. PRINCE GEO	RGES		RIVERD	ALE				1 XYes 2 □ No
or 28	Director	10e. Street and Number			10f. Zip Code			10g. C	itizen of What Co	ountry?
s 23e	rai	6009 64th AVE	2. Was Decedent Ever in U.S	10.1		737	-i-2 (Cit-	Van an Na	USA 14. Race - Ame	origan Indian
72 hours after death with the Maryla "neturer", or Items 23e or 28s-1 show alcal Examiner must be multised at	Funeral	11. Marital Status 1. Never Married 2 Married 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	Armed Forces?	i	Was Decedent of f Yes, specify Cul			n, etc.)	Black, Whi	
ours a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 1983 Year or Dates: 199		1⊡Yes 2. XXNo	Specify:			Specify:	BLACK
72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occu	during mos	t of working	16b.	Kind of Business	/Industry
within sne. than	dmo	Elementary/Secondary (0-12)	Coilege (1-4or 5+)	life. I	DO NOT use retir U.S. MA	•			DEFENS	:r
filed Hygid Sther ent, I	ပိ	17. Father's Name (First, Middle, Last)			U.S. FIA		er's Name (Fir	rst, Middle, Maide		115
fental rked c	OB	JIMMY EDWAR	DS WHITE				BONNI	E L.	EDWARD	S
permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiens. Importent: If item 27 is marked other than "neny injury or other traumatic svent, It a Mad once.		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Stree	t and Numbe	er or Rural Ro	ute Number, City	or Town, State,	Zip Code)
and and m 27		BONNIE L. EDWARDS	·			INTE I		REENVILL		
Q = 10 H		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Re	moval from State	metery, crer	sition (Name of natory or other pl		Date		Location - City or	
rt. Pa rtmen rtent: njury		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service #dense			N NAT L.  Name and Addi			2005 AR	LINGTON,	VA.
Depa Depa Impo eny it		21. Signature of Puneral Service Albertser	Chenco MOOD	C	HAMBERS	<b>FUNERA</b>	AL HOME	& CREM	ATORIUM,	P.A.
100 VI		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death.					RIVERDA spiratory arrest,	bb, rw.	Approximate Interval Between
Cate be executed which is a property of the burial-transit the burial-transit can be executed with the burial-transit can be e	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
physicate by the sthe	ogle	d.								
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregnar  1 Live birth 2 Fetal  4 Pregnant at time of de  9 Unknown	death 3□	Ectopic pregnand Other (specify)	су			23d. Date of de Month	olivery Day Year
urres mar u signed by Id be detad	by	Part II. Other significant conditions conf	ributing to death but not resu	fting in the u	nderlying cause g	iven in Part I		23e. Did tobacco	_	o the cause of death?
<b>'sicien:</b> The taw requir s certificate has been si lirector, page 2 should I	Completed							24a. Was an autopsy performed?	prior to death?	utopsy findings availabl completion of cause of
	C	25. Was case referred to medical				26 Place		1 ☐ Yes 2 💢 N	lo 1 ☐ Yes	s 2 No
o the Aospitel or Attending Physicien: The inthin 24 hours after death.  of the Funerel Director: After this certificate his or the Funerel Director. After this certificate his ompletely filled in by the funeral director, page	n: To B	examiner? 1 ☐ Yes 2 X No  27. Manner of Death	28a. Date of Injury	R/Outpatier 28b. Time of	IL 3 DOA	ther: 4 □ Nu	ursing Home	5 Residence Describe how in	_ ( ,	əcify)
To the Hospitel or Attending Physicien: within 24 hours after death or at the Funete Director. After this certification the Funete Director. After this certification by the funeral director.	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	(Month, Day Year)  28 - lace of Injury - At hor	Injury me, farm, str	M 1[	]Yes 2□	28f.			ural Route Number,
tel or s aftel st Dire	Cert	4  Homicide	wilding, etc. (Specify,	,				City or Town, Sta	110)	
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A pompletely filled in by the fu	edical (	29a. Certifier 1 C ifying P is (Check only one) 2 redical Ex in	er: O the basis of examinati a manner stated.	vieuge, ueati on and/or in	vestigation, in my	thre, date an opinion, dea	iu piace, and ath occurred a	due to the cause t the time, date a	s) and manner a nd place, and du	s stated. e to the cause(s)
To the To	Me	29b. Signature and title of certifier				nse number		1	ate signed (Mon.	*
		1 rento	~~		1	5033	5		5-4-	. 05
1+1		30. Name and address of persons con DR KAYMOND LYCAS	npleted cause of death (Item 3001 Ho				CHEV	ERLY, M	D 201	85
Sta		31. Date filed (Month, Day, Year)	32. Augistrar's Signat	ure A	packet					

DHMH 17 Rev 1/2001

Registrar

			State of Maryland / Dep	ertificate of Death	9								
	0		Decedent's Name (First, Middle, Last)	2. Date of	of Death 3. Time of Death								
	Physici /Medi		Earle Bates Ford	May 8	3, 2005 Year 07:30 a M								
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death								
			104 Piver Lane	Millington	Queen Anne's								
L	Funeral Director		5. Social Security Number  218-24-2548  Usual Residence of Decedent  6. Sex 1 M 2 F 7. Age (In yrs. last birthday 1 M 2 F 89 Yrs.		of Birth hor, Day, Year) 9. Birthplace (State or Foreign Country) 18/1915 M.D.								
	/land		10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits								
	within 72 hours after death with the Maryland ane than "natural", or items 23a or 28a-f show to Wedical Examera munit beau willful at	tor	MD Queen Anne's Milli	ngton	1 ☐ Yes 21② No								
	or 28,	by Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?								
	23a dans	alc	104 Piver Lane	21651	USA								
	ems	Iner	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.	r No- 14. Race · American Indian.								
36	s afte	YF	1 Never Married 2 Married 1 Yes 2 No If Yes, Give	1 ☐ Yes 🌠 No Specify:	Specify: White								
Ö	hour tural'	q pe	3 XWidowed 4 Divorced Year or Dates:	adopto Heuri Oppunation									
<del>1</del> 5	in 72	lete	(Specify only highest grade completed) (Giv	edent's Usual Occupation a kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry								
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryla it of Health and Menlarl Hygiene. It filem 27 Is marked other than "natural" or Items 23s or 28s-f show if it them 27 Is marked other than "natural" or Items 23s or 28s-f show or other traumatic event, the Medical Examera minimal Let suffice I at the Indianal and the content of the Indianal	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Farming	Agriculture								
	e filed I Hygid other	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mi									
/lar	should be to nd Mental I marked o	ToE	Ernest Ford	Mary Wa	rner								
Maryland	2 sho and I Is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ing Address (Street and Number or Rural Route N									
	1 and Health Iem 27 Sther tr		Earle F. Ford/son 1	06 Piver Lane Milli	ngton, MD 21651								
Baltimore,	Pages 1 nent of H ant: If ited ary or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cre	osition (Name of Date Imatory or other place)	20c. Location - City or Town, State								
Ei m	Pa ant ury		`4 □Donation 5 □Other (Specify) Sudlers	ville 05/12/	2005 Sudlersville								
Bal	permit. Pa Departmen Important: any injury		21. Signature of Funeral Service Licensee	Name and Address of Facility Fellows, Helfenbein	n & Newnam F.H.								
	462 0 0		23a Part 1. Enter the disease, or complications that ceused the death. Do not en										
			snock, or heart failure. List only one cause on each line.	ites the mode of dying, water as cardiac or respirate	Interval Between Onset and Death								
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)										
	Examiner		Due to (or as a consequence of):	ulitus olcen									
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events  c.										
0	be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of):	·									
8760,	w = w	Ilcal	d										
x 68	leath certifical attending phy afor use as th	Mec	IF FEMALE:										
Вох	ath co	ian/		□Ectopic pregnancy	23d. Date of delivery  Month Day Year								
0	res that the death signed by the atter be detached for u	Physician/Med	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 5	Other (specify)	-								
σ.	that the by detact		Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. I	Did tobacco use contribute to the cause of death?								
Records,	puires than signed I	d by	Methorimen's Demenia		1 Yes 2 No 3 Probably 4 Unknown								
00	w requir s been si should	Completed		24a. \	Was an 24b. Were autopsy findings available								
Re	The lav le has age 2	mo			performed? prior to completion of cause of death?								
Vital	ysician: The lis certificate hadirector, page	0	25. Was case referred to medical	1 ☐ Y 26. Place of Death (Check o									
f V	ysici iis cei direc	To B	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatie	ont 3 DOA Other: 4 Nursing Home 5	Residence 6 Other (Specify)								
n of			27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	of 28c. Injury at 28d. Desci Work?	ibe how injury occurred								
Sio	endin eath. or: Al	catle	2 Accident investigation	M 1 Yes 2 No									
Division	or Attencater death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, s building, etc. (Specify)	treet, factory, office 28f. Locati City of	on (Street and Number or Rural Route Number, r Town, State)								
	pital ours a eral C		29a. Certifier 17 Certifying Physician: To the best of my knowledge, dea		Alexander and a second a second and a second and a second and a second and a second and a second and a second and a second and a second and a second a second and a second and a second and a second and a second and								
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea (Check only one) 1 Certifying Physician: To the basis of examination and/or in anythanner stated.	th occurred at the time, date and place, and due to ovestigation, in my opinion, death occurred at the ti	me, date and place, and due to the cause(s)								
	rothin Fo the	Me	29b. Signature and title of centrier	29c. License number	29d. Date signed (Month, Day, Year)								
	·- > E 0		1 / Muliel El	DODG 0301	5/10/05								
			30. Name and address of person Mno completed cause of death (Item 23a) (Type	DOOG 301									
			MICHAEL BYGIMER, MD 1225Pe	fen ku. Sifs chesten	1000. MU 2160								
:	Sta		31. Date filed (Month, Day, Year)  MAY 1 1 2005  32. Figistrar's Signature	Sade,									
	Registi	rar	DAT. I I Zuus										

			1 - State Registrar	State of Ma		Depa		of Hea	alth a		ntal Hyg	9	5 172	41	
	Physici /Medio	cal	Decedent's Name (First, Middle, Last)     Nina S. Fisher  4a. Facility Name (If not institution, give				4b. City, Tov	vn, or Lo	cation of	N	Date of Deat Month Iay 05	Day Year	145	p M	
8	Funeral Director	lei	Malcolm Grow Medi 5. Social Security Number 578-24-3913	cal Cente	r e (In yrs. last 79	<i>birthd</i> ay) Yrs.	Camp If Under 1 Y Months D	ear If	ngs Under 24 Hours	Min.	Date of Birth (Month, Day, vember 2		George's inthplece (State or Fountry)	oreign	
	John Colling Manual 22 stous aries deem with the way yand. Mental Hygiene. Arked Other than "natural", or items 23a or 28a-f show atic event, the Medical Examiner must be notified at	Director	Usuel Residence of Decedent  10a. State 10b. County  Maryland Prince Geor  10e. Street and Number	rge's	10c. City, To	Sprir		do			11/	0g. Citizen of What C	10d. Inside City Limits 1 ☐ Yes ※XXNo		
	is 23a or	eral Dir	6018 Darel Street	12. Was Decedent E	Ever in U.S.	13 \	2074	46	anic Origi	in? (Specif		USA 14. Race - Arr			
920	ral', or item	by Funeral I	1 Never Married 2XXXMarried 3 Widowed 4 Divorced	Armed Forces?  1 ☐ Yes 2 ☒ N  If Yes, Give ☒  Year or Dates:			Was Decedent f Yes, specify 1 ☐ Yes 2√☐		Mexican,	Puerto Rio	an, etc.)	Black, Wh	ite, etc.		
D-0171	sne. than "natu	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		+)	(Give life. l	dent's Usual O kind of work of DO NOT use r ary/Booke	lone durii etired)	n ng most o	of working		16b. Kind of Busines	•		
Maryiand 21215-0036	and of Mental Hygiene.  The Mental Hygiene.  The Mental Hygiene.  The Mental Hygiene.  The Mental Hygiene has a second of the manual be motified at the manual be motified at the manual be motified.	To Be Co	17. Father's Name (First, Middle, Last) Milton L.G. Smit		1.30	tieta	II y/ DOOKE			s Name (/	irst, Middle, N	Catholic Chu Maiden Sumame)	irch		
, Mary	alth and N 27 Is ma		19a. Informant's Name/Relationship (Ty Paul Fisher / Husband		1		-					City or Town, State, land 20746	Zip Code)		
pailliore,	points. Tages a raid should be partment of Health and Menta Important: If item 27 is marked any injury or other traumatic events.		20a. Method of Disposition 1 文章urial 2 □ Cremation 3 □ R 1 □ Donation 5 □ Other (Specify)		ceme	ectic	sition (Name of matory or other on Cemete	rpiace) ery		Dat 7 10, 1		20c. Location - City o Linton, Mary			
	Departi Import any inj		21. Signature / 1 Funeral Service Leens	/		61		Hill	Road	Oxon 1	Hill, Man	las Funeral ryland 2074	Home P.A.		
*	hysician /Medical		23a. Party Enter the disease, or complete shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused ne cause on each lin  Lung C  Due to (or as a	ancer		er the mode of	f dying, s	such as ca	ardiac or r	espiratory arre	est,	Approximate Interval Between Onset and Des	en ith	
,00,	ysicien and e burial-transif	cai Examiner													
115001d3, r.O. DOA 00	led by the attending physic detached for use as the l	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2\$\infty\$No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea		]Ectopic pregr ] Other (specif					23d. Date of do	elivery Day Yea	ır	
, (2)	in signed by	ed by Pr	Part II. Other significant conditions con	ntributing to death bu	ut not resultin	g in the u	nderlying caus	e given i	n Part I.			acco use contribute	to the cause of deal		
יייייייייייייייייייייייייייייייייייייי		Completed									24a. Was ar autopsy perform 1 🗆 Yes 💈	y prior to ned? death?	autopsy findings ava completion of caus s 2 No	tilable se of	
	ith. The this certificate has funeral director, page	atlon: To Be	25. Was case referred to medical examiner?  1  Yes 2 Maner of Death  1 Natural 5 Pending investigation	Hospital: 1 ☐ Inpaties 28a. Date of Injur (Month, Day	nt 2 🖾 ER/ y 28t 'Year)	Outpatien o. Time of Injury		Other: Injury at Work?	4 🗌 Nurs	sing Home		g) nce 6 Other (Sp w injury occurred	ecify)		
	Dig after	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc	ury - At home, c. (Specify)	farm, str	eet, factory, of	fice		28f. Location (Street and Number of City or Town, State)			Rural Route Numbel	5.	
	in 24 hours the Funerel	Medical	(Check only 2 Madical Exami	sician: To the best of ner: On the basis of and manner sta	examination		vestigation, in	my opinio	on, death		at the time, da	ite and place, and du	ue to the cause(s)		
	within 2 To the complet	2	29b. Signature and title of certifier	J Hell	24		L	A		368		3d. Date signed (Mor			
*	- (1) Sta	ite	30. Name and address of person who ad Brian J Heller 105 31. Date filed (Month, Day, Year)	UWest Per		Rd,		s AF	B MD	, 207	62 _	(			
	Regist	ar	MAY 1 0 2005	Mayer	, #	Com	42								

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** A M MAY 8 TERESA AGNES FARNUM 2005 1:40 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNAPOLIS SUNRISE ASSISTED LIVING ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🛣 F 79 OCT. 7, NY Director 126-14-6501 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location rai', or itams 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ▼ No MD ANNE ARUNDEL ANNAPOLIS Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 800 BESTGATE ROAD 21401 USA death Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or item any injury or other traumatic event, the Medical Evented once. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 WHITE f Yes, Give Year or Dates: 1 ☐ Yes 2 📉 No Specify: Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry DEPARTMENT OF Elementary/Secondary (0-12) College (1-4or 5+) **ARMY** PERSONNEL ACTION 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOSEPH DEMBAR MARY TIERNEY 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 509 EPPING FOREST RD., ANNAPOLIS, MD TERESA F. BRITTINGHAM/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State COMFORT CEMETERY 05/11/2005 ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Pan 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetat death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 Yes 2 No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performle ormod?. 2 **∑** No certificate 2□ No 1 ☐ Yes 1 🗌 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pending investigation Natural death. М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deati To the Funeral Director: in by the 6 Could not e 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The dical saminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and Mie of o 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOPRH, M.D. 31. Date filed (Month, Day, Year) 32. Registrat's Signature State 9 2005 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

-			1 - For State Registrar	State of Maryla		artment of F			ene2005	17246			
	Physici	an	Decedent's Name (First, Middle, Last					2. Date of Death Month	Day Year	3. Time of Death			
	/Medi		GEORGE DOUGLA	AS FLETCHER,	JR.			MAY 6		11:00 A M			
	Examir	ner	4a. Facility Name (If not institution, give	,		4b. City, Town, or	Location of Death		4c. County of Dea	th			
			23820 JANBEALL (				SBURG		MONTGOMERY				
L	Funeral Director		5. Social Security Number 6. S 219-48-3780  Usual Residence of Decedent	ex   7. Age ( <i>ln yrs</i> <b>⊠</b> M 2 ☐ F   57		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan - 18		thplace (State or Foreign ountry) aryland			
	viand ow		10a. State 10b. County	10c. C	ity, Town or Lo	ocation		<u> </u>		10d. Inside City Limits			
	Man fied	ţō	Md. Monto	gomery	Clarks	burg				1 ☐ Yes 2 No			
	r 28s	lec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?			
	th wit	a D	23820 Janbeall (	Court			20871		United S	tates			
	dea	Funeral Director	11. Marital Status	12. Was Decedent Ever in U	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame					
9800	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Executors the notified at	by	1 ☐ Never Married 25€ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No I	.966	1 ☐ Yes 2 ☑ No	Specify:	rrican, etc.)	Black, White	White			
21215-0036	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Items 23a or 28a-f show thit, the Medical Exercitive trast be redified at	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of work ()	ring	6b. Kind of Business	/Industry			
2	filed w Hygien other th	S	12	2	Senio	r Project				nstruction			
pu	d oth	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma	,				
yla	2 should be f and Mental h is marked of raumatic ever	2	George Douglas	Fletcher				ita Blos					
Maryland	nd 2 should lith and Mer 27 is marke f traumatic		19a. Informant's Name/Relationship (Christine W. Fle	•		ng Address <i>(Street :</i> 20 Janbea			City or Town, State, I urg, Md.	Zip Code) 20871			
ē,	permit. Pages 1 and 2 of Department of Health ar Important: If item 27 is any injury or partief traugure.		20a. Method of Disposition		Place of Dispo	sition (Name of matory or other place	1		Oc. Location - City or	Town, State			
Baltimore,			1 🗹 Burial 2 ☐ Cremation 3 ☐  `4 ☐ Donation 5 ☐ Other (Specify	Removal from State			,	11/05	Neelsvill	5M e			
E E	mit. I		^4 □ Donation 5 □ Other (Specify) Neelsville Cemetery 5/11/05 Neelsville, Md.  21. Signature of Funeral Service Licensee Muriel H. Barber Funeral Home										
m	Medical / Medical / Medical / Medical / Medical / Medical		> murel 5	V. Rasher		Muriel H	<ul> <li>Barber</li> </ul>		Home ville, Md	00000			
			t,	20882 Approximate Interval Between									
	Povsiciao		shock, or heart failure. List only Immediate Cause (Final		T CELT	Time cas	arr.			Onset and Death			
			disease or condition resulting in death)	Due to (or as a conse		LUNG CAN	CER			2 YEARS			
	Examiner			·									
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Eller Underlying Cause (Disease or injury	b. Due to (or as a conse	quence of):								
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	C									
8760,	cian a		Tooding in doding East	Due to (or as a conse	quence or):								
87	physi s the b	dical		. d									
D. Box 6	The law requires that the death certificate tie has been signed by the attending phys age 2 should be detached for use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown								ivery Day Year			
P.O	that th	Phy	9 Unknown		and the share of		- 1. B 11	OC- Didash		the server of death?			
Records,	w requires the been signer should be d	ted by	Part II. Dther significant conditions c	ontributing to death but not re-	suiting in the ui	nderlying cause give	en in Paπ I.		cco use contribute to 2 □ No 3 □ Pr	. /			
l Rec	The law r ate has be page 2 sh	Completed				-		24a. Was an autopsy performs	prior to	stopsy findings available completion of cause of			
Vital	ician: T certificat rector, pa	Be (	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one)					
of V	di S	2	1 Yes 2 No	Hospital: 1 Inpatient 2	] ER/Outpatien	nt 3□ DOA Othe	er: 4 🗆 Nursing Ho	me 5 Residen	ce 6 Other (Spe	cify)			
ion	ling 1. After fune	ation:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	rat k? Yes 2 □ No	28d. Describe how	injury occurred				
É	in Direction	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	iome, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,			
	To the Hospital or within 24 hours afte To the Funeral Dis completely filled in	edical (	29a. Certifier (Check only one) 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examin- and manner stated.	owledge, death ation and/or inv	n occurred at the tim vestigation, in my op	ne, date and place, pinion, death occurr	and due to the cau red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)			
	To ti withii To ti comp	Me	29b. Signature and title of certifier	11-00-1	10	29c. License	number	290	. Date signed (Monti	h, Day, Year)			
	10+1		+ toseph M	Hazzerty is	4)	D :	D 32407			005			
	1		30. Name and address of person who of JOSEPH M. HAGGER				ER DR., #	300, ROCE	WILLE, MD				
	Sta Registr		31. Date filed (Month, Day, Year)	32 Aegistrar's Sign	ature	all	• ''		-				

			1 - For State Registrar		Maryland / Dep <i>Ce</i>		Health and	Mental Hyg	_	17247	
	0		1. Decedent's Name (First, Middle	, Last)				2. Date of Dea	th Day Year	3. Time of Death	
	Physici /Medio		RI	EGIS L.	FINUCAN			Month MAY	4, 2005	10:05 P M	
)	Examin		4a. Facility Name (If not institution,	give street and number	er)	4b. City, Town,	or Location of Deat	th	4c. County of Death		
			HOLY CROSS	5 HOSPITAL		SI	LVER SPRI	ING	MONTGOM	ERY	
	Funeral		5. Social Security Number		Age (In yrs. last birthday	Months Days			9. Birtl	nplace (State or Foreign untry)	
ш	Director		185-12-6287	1 <b>∑</b> M 2□ F	80 Yrs.			OCT. 4,	1924	PÄ.	
	pu s		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits	
	lanyla aho	5			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					1 TYYes 2 □ No	
	ha N	ect	MD. MONTGO	DMERY		WHEATON			10- Citizen of Miles Co		
	with	급				10f. Zip Code	20006		10g. Citizen of What Co	-	
	s 23	eral	12502 ATHER	12. Was Deceder	at Ever in II C 12	Was Doodent of I	20906	Specific Vest of No.	U.S. A		
	itam	Funeral Director	11. Marital Status  1 ☐ Never Married 2 ▼ Marri	Armed Force	s?	Was Decedent of I If Yes, specify Cub	oan, Mexican, Puer	to Rican, etc.)	Bleck, White		
99	Irs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	1944-	1 ☐ Yes 2 🗶 No	Specify:		Specify:	WHITE	
21215-0036	d within 72 hours after death with tha Maryland jena. r than "natural", or itams 23a or 28a-f ahow It e Madical Examble rout to be natified at	ed	15. Decedent	's Education	1940 16a. Dece	edent's Usual Occu	pation		16b. Kind of Business/		
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212	77 77 -	E	12	College (1-40		DISPLAY I	MANAGER		DEPARTMENT	T STORE	
	othe othe	BeC	17. Father's Name (First, Middle, I	Last)			18. Mother's Na	me (First, Middle,	Maiden Sumame)		
<u>a</u>	should be by Mental markad o	ToE	BERNARI	) FIN	UCAN				RILEY		
Maryland			19a. Informant's Name/Relationsh	nip (Type, Print)	19b. Mail	ing Address (Street	t and Number or R	ural Route Numbe	r, City or Town, State, Z	Tip Code)	
	1 and 2 Health a iem 27 is		DOLORES M. FI	NUCAN/WIFE	1250	2 ATHERTO	ON DR., W	HEATON,	MD. 20906		
ore.	of He of He item		20a. Method of Disposition	o	20b. Place of Disp cemetery, cre	osition (Name of omatory or other pla	ice)	Date	20c. Location - City or	Town, State	
altimore,	parmit. Pages Department of I Important: If it any injury or o		1 ☐ Burial 2 ▼Cremation 1 ☐ Donation 5 ☐ Other (Sp	3 ⊔Hemovai from Sta necify)		S CREMATO	ORY 5-6	-2005	RIVERDALE	MD.	
ä	mit. partn ports y inju		21. Signature of Funeral Service L	icepsee /	2 2	2. Name and Addre	ess of Facility				
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	Pnysician		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)		sed the death. Do not en line.  MYOCARDIAL	iter the mode of dyi	ing, such as cardia	c or respiratory arı	est,	Approximate Interval Between Onset and Death HRS •	
760,	Medical Examiner  bhysician and stransit sthe burial-transit	ical Examiner	Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. HYPER Due to for:	as a consequence of): TENSION as a consequence of): as a consequence of):						
.O. Box 68	death certif e attending ed for use as	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3 tat time of death 5	□Ectopic pregnanc □ Other (specify) _	ży		23d. Date of deli Month	very Day Year	
Records, P	es ign	by	Part II. Other significant conditio		but not resulting in the	underlying cause gr	ven in Part I.		bacco use contribute to es 2 □ No 3 □ Pro	the cause of death?	
O S S	aw requir	Completed						24a. Was a		topsy findings available	
æ	The law ate has page 2 s	E O						autop: perfor 1 Yes	med? death?	completion of cause of	
Vital		a	25. Was case referred to medical				26. Place of De	ath (Check only or	24	22.10	
<u>&gt;</u>		0 8	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 🙀 Inpa	atient 2 ER/Outpatie	nt 3 DOA Ot	her: 4 Nursing I	lome 5 ☐ Resid	ence 6 Other (Spec	rify)	
of	g Physer this seral di	n: T	27. Manner of Death	28a. Date of Ir			iry at		ow injury occurred	,,	
0	Attending r death. sctor: After by the funer	atlo	1 Natural 5 Pending 2 Accident investig	9	bay roas, injury		Yes 2 No				
Division	l or Attendafter deatl	ific	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ned 289. Place of	Injury - At home, farm, st etc. (Specify)	reet, factory, office		28f. Location (S City or Tow	treet and Number or Ru	ral Route Number,	
	s after s afte	Certification:	4   Homoleo	building,	oto. (opoony)			Ony or von	., 5.0.0)		
ŕ	To the Hospital or Attending PP within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifyin (Check only one) 1 Medicel	g Physicien: To the be Examiner: On the basis and manner	st of my knowledge, dea s of examination and/or in stated.	th occurred at the tinvestigation, in my	ime, date and place opinion, death occi	e, and due to the curred at the time, c	ause(s) and manner as ate and place, and due	stated. to the cause(s)	
	To the within To the Comp	M	29b. Signature and title of certifier	0 1		29c. Licen:	se number	2	9d. Date signed (Month	_	
	2+1		Suem	of wild		<b>v</b> D:	14876		5-5-65		
	okt 1		30. Name and address of person	who completed cause o	of death (Item 23a) (Type	, Print)			J		
			SURESH C. 31. Date filed (Month, Day, Year)	GUPTA, M.D	strar's Signatura	KKY ST.,	MT. RAIN	ILER, MD.	20/12		
	Sta Registi		MAY 0	2005	of death (Item 23a) (Type 3503 PE strar's Signature						

		1 - For Stata Registrar	State of Maryla			of Healt of Dea			Reg. No	2001	5 1721
Physici /Medio Examin	al	Decedent's Name (First, Middle, Lasi     THELMA M • (	GOODING		4b. City, T	own, or Locat	ion of Death	2. Date of De Month MAY	5 Da	y Year 2005 County of Dea	3. Time of Death  10:30p M
Funeral Director		13210 Roseda 3 5. Social Security Number 6. Se	e Cannery	s. last birthday)	If Under 1	11 Po Year If Ur Days Hou	der 24 Hrs.	(Month, Da	th ly, Year)	Kent 9. Bi	thplace (State or Foreign
with the Maryland a or 28a-f show	Funeral Director	Usual Residence of Decedent           10a. State         10b. County           MD         Kent           10e. Street and Number	10c. C	City, Town or Lo	ond 10f. Zip (			reb z		izen of What C	elaware  10d. Inside City Limits  1 □ Yes 2∑ No ountry?
ges 1 and 2 should be filed within 72 hours after death with the Maryla at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Evaninar must be notified at	Ď	13210 Roseda1  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	U.S. 13. 1	Was Deceder f Yes, specifi 1 Yes 22	No Spe	cify:	pecify Yes or No Rican, etc.)	•	S • A •  14. Race - Am. Black, Whi  Specify: V	te, etc. Vhite
e filed within 7 Il Hygiene. other than "r	Be Completed	(Specify only highest grad Elementary/Secondary (0-12)  8  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	life.	OMEM 2	ker	<u>-</u> -	e (First, Middle,		Own Ho	ome
id 2 should be file th and Mental Hy 27 is marked oth traumetic event	70 B	William F. Fen  19a. Informant's Name/Relationship (7)		19b. Mailir	ng Address (			. Thie			Zip Code)
Permit. Pages 1 and in pages 1 and in partition of Health mportant: If item 27 in y injury or other transce.		Marie Ann Thom  20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☑ F  1 ☐ Donation 5 ☐ Other (Specify)	20b. Removal from State	Place of Dispo cemetery, cren	sition (Name natory or oth	of er place)		Date	20c. Lc	ocation - City or	Town, State
permit. Page Department of Important: if any injury or once.		21. Sural Servic Lines	M005	$ \begin{array}{c c}  & G^{22} \\ \hline 510 & 11 \end{array} $	Name and 1ena 8 We	Fune Fune st Cr	ral F oss S	Iome of	St	ephen	L. Schaed 21635
Pnysician /Medical Examiner		28a. Pant Enter the disease, or completion, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	0 1119 66				or respiratory ar	rest,		Approximate Interval Between Onset and Death
	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quarios of):	0518	com	en/+7	ly Pisc	113	6	YUMKS
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	ive birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy regnant at time of death 5 ☐ Other (specify)						23d. Date of del Month	ivery Day Year
w requires that been signed t should be deta	þ	Part II. Other significant conditions con	ntributing to death but not re			se given in Pa	art I.				the cause of death? obably 4. Unknown
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hys this al dii	10 B	eyaminer?	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury			Nursing Ho	me 5 Nescribe h	ence 6	Other (Spec	city)
ital or Attendii us after death. ral Director: A led in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ify)				City or Tow	n, State)		ral Route Number,
he he	Medical	29a. Certifier (Check only one)  2 Medical Examination  29b. Signature and title of certifier	sician: To the best of my knier: On the basis of examination and manner stated.	owledge, death ation and/or inv	estigation, in	my opinion, o	death occurr	ed at the time, d	late and	place, and due	to the cause(s)
<b>L34</b> 8	-	James & La	eay/			POO 5			.ou. Date	signed (Month	
		30. Name and address of person who co  James E. Lacey 31. Date filed (Month, Day, Year)		Wash:		n Ave	. Che	esterto	own,	MD.	21620

			1 - For State Registrar	State of Maryland		rtment e tificate				jiene	05	17250	
	Physici		1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month May	Day	Year 2005	3. Time of Death  12:15 A M	
	/Medic Examin		Vivian H. Gassa 4a. Facility Name (If not institution, give str	eet and number)		4b. City, To	wn, or Locat	tion of Death	4c. County of Death			12:13 A	
			Laurel Regional Ho	spital		Lau	rel			Princ	e Geo	rge's	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Months C	Year If Ur Days Hou	nder 24 Hrs.	8. Date of Birth (Month, Day			ace (State or Foreign	
	Director		377 30 3270	<sup>4 2</sup> ₩ 60	Yrs.				Novembe			ington, DC	
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, 7	Town or Loc	cation					11	Od. Inside City Limits	
	Maryl 1 sho	Į.	MD Prince Ge	orgoto I	aure1						ty⊡Yes 2 □ No		
	28a-	Director	10e. Street and Number	orge s L	aurer	10f. Zip Ce	ode			10g. Citizen of What Country?			
	3a or	Ī	9045 Thamesmeade R	oad # H		2072					U.S.A.		
	death	Funeral	7	. Was Decedent Ever in U.S. Armed Forces?	13. V			o Origin? (Spe xican, Puerto I	14. Rac	e - America			
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Maryland 21215-0036	ural',	d by	3 Widowed 4 Divorced	Year or Dates:						Specif	y: Bla	ıck	
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an	d ta b	To Be	William Page					llie B					
ar <sub>2</sub>	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or iteme 23a or 28a-1 show eumatic event, the Medical Examinat mast be notified at	-	19a. Informant's Name/Relationship (Type	, Print)	19b. Mailin	g Address (S	Street and Nu	umber or Rura	l Route Number	, City or Town,	State, Zip	Code)	
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Ze,			20a. Method of Disposition	20b. Plac	e of Dispos	sition (Name natory or othe	of er place)	D	ate	20c. Location	City or To	wn, State	
Ĕ	Pages nent of h ant: if ite		1  Burial 2 □ Cremation 3 □ Rer 1 □ Donation 5 □ Other (Specify)	noval nom State		Cemete		5/10	/05	Landove	r,Mar	yland	
Baltimore,	permit. Pag Department Importent: i any injury o		21. Signatur of Reneath ervir.	- T				acility J.	B. Jen				
<u> </u>	82583		1 XXXX	1	74	74 Lar	ndover	Road :	Landove	r, Mary	1and	20785	
П			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death. cause on each line.	Do not ente	or the mode of	of dying, such	h as cardiac o	r respiratory arr	est,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Pneumonia							- 1	Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequer	nce of):						1.0		
	LAUIIIIICI	_	Sequentially list conditions, b.	Carcinoma I  Due to (or as a consequer									
	led Isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			· · · · · · · · · · · · · · · · · · ·	ıma IVJ						
	be executed sicien and burial-transit	Examiner	that initiated events c. resulting in death) Last	Chronic Obs		ive ru	ing Di	sease					
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89	ificate g physi as the t	edic				*							
ŏ	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c	. If yes, outcome of pregnance		Estania araa				23d. Da	te of deliver	у	
m m	deat	sicia	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant at time of deat		Ectopic pregi Other (speci				Mo	onth I	Day Year	
<u>Р</u> .	at the	hys	9 🗆 Unknown										
	res that the de signed by the a be detached t	by F	Part II. Other significant conditions contri	buting to death but not resulting	ng in the un	derlying caus	se given in P	art I.				e cause of death?	
ord	w require been si should I	ted	Hypertension		_				1 L Y	es 2 No	3 X Proba	ıbly 4 ∐Unknown	
Records,	law law las b	nple	Carcinoma of 1t	Breast					24a. Was a autops	y	Were autop	sy findings available ipletion of cause of	
	The lav	Completed							1 Yes	ned?	death? 1 🗌 Yes :		
Vital	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	spital:				lace of Death	(Check only on	Θ)			
ot	Phye this al di	5	1 162 5 7 140	1 Inpatient 2 K EH	VOutpatient Bb. Time of	3□ DOA	-		ne 5 Reside				
L C	fte fte	tlon	1 XNatural 5 ☐ Pending	(Month, Day Year)	Injury	M 200.	Injury at Work? 1 ☐ Yes 2		8d. Describe ho	w injury occur	red		
Division of	Attendideath.	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At home	a, farm, stre		- T		28f. Location (St	reet and Numb	er or Rural	Route Number.	
2	after Dire	erti	4 Homicide determined	building, etc. (Specify)					City or Town				
	pepite hours inerel y filler		29a. Certifier 1 Certifying Physic	ian: To the best of my knowle	dge, death	occurred at 1	the time, date	e and place, a	and due to the ca	ause(s) and ma	anner as sta	ited.	
	To the Hospitei or Attending within 24 hours after death. To the Funerei Director: After completely filled in by the fune	Medical	(Check only 2 Medical Examine one)	r: On the basis of examination and manner stated.	and/or inv	estigation, in	my opinion,	death occurre	ed at the time, d	ate and place,	and due to	the cause(s)	
	To the To the Comp	Σ	29b. Signature and title of certifier	. MIL a	0	29c. L	icense numb	oer	2	9d. Date signe	d (Month, E	ay, Year)	
			18AUGO M	10. AHENDIL	9	D	42580			May 6,	2005		
0	[7]		30. Name and address of person who com										
			Parmjit Aujla M.D.			# 3 B	laden:	sburg,	Marylar	nd 207	10		
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 0 2005	3 Registrar's Signatur	ho	E .							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day AROL 725 GASKINS may 3 2005 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** of Maryland Medical Center University BALTIMOIZE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 220-58-5029 1 □ M 200XF **Director** Jan 25,1952 53 Washington D.C. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Heatth and Mental Hygiene.
int: If item 27 is marked other then "naturel", or Items 23a or 28e-f ehow 10c. City, Town or Location 10a. State 10b. County item 27 is marked other then "naturel", or Items 23a or 28e-f ehow other treumetic event, the Madical Examinar must be positived at 10d. Inside City Limits Completed by Funeral Director 1 ☐ Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7183 Stillwater Ct. United States 21702 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ☐ Yes 21 No f Yes, Give ∕ear or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry 5+ College (1-4or 5+) Clinical Professional Comprehensive Elementary/Secondary (0-12) Counseling Associates Counselor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bernard Paskin Ethel Goldinher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 is eny injury or other tre once. 7183 Stillwater Ct., Frederick, MD 21702 Rick Gaskins / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 5-9-05 Frederick, Maryland \*4 ☐ Donation 5 ☐ Other (Specify) Frederick Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 Drocke 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician disease Due to (or as a consequence of): disease or condition arteru resulting in death) /Medical Examiner stage Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transi that initiated events Millin dependent attending physician and for use as the burial-trai resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical peripheral Vascula IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal dea 4 Pregnant at time of death 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has autopsy performed? 1 ☐ Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 X Yes 2 ☐ No this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 29c. License number 3,2005 P14737 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manuel Torres 22 South Greene Street , Baltimore

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

istrar's Signatures

		1	State Registre AMEND TIEM #	State of Mary 4aPER PHY&1				Reg		
	sicia: ledica	n	<ol> <li>Decedent's Name (First, Middle, Last</li> <li>Lillian Baker Gies</li> </ol>	")			•	2. Date of Death Month May 9, 20	Day U Vear	3. Time of Death 8:30 PM
1	amine		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death	h	4c. County of Death	
Fune Direc			5. Social Security Number 6. Se 218–50–2840	TM 2XIE	yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days		8. Date of Birth		place (State or Foreign http) 1and
aryland	18 20		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 📉 No
death with the Maryland ms 23a or 28a-f ahow	3 0	JI e	Maryland Frederick 10e. Street and Number 3384	Fr	ederick	10f. Zip Code			Citizen of What Coul	
ō .≝ ¹			6384 Urbana Pike  11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	li i	21704  Vas Decedent of H f Yes, specify Cuba  □ Yes 2X No	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify: Whit	etc.
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. T's marked other than "natural; or	evalit, tils manifest E	Completed	15. Decedent's Education (Specify only highest grade (Specify only highest grade (0-12) 1 1	ucation	16a. Deced (Give life. L	lent's Usual Occup kind of work done o DO NOT use retired	ation during most of wor d)	tking	b. Kind of Business/In	
land 2 lid be filed lental Hygic	2	0	17. Father's Name (First, Middle, Last) Franklin S. Gladhi	11	Пошеша		18. Mother's Nan	ne (First, Middle, Mai	vn home den Sumame)	
	500000000000000000000000000000000000000		19a. Informant's Name/Relationship (Ty Peggy Ann Webb, da	/pe, Print)		g Address (Street	and Number or Ru	ral Route Number, Ci		
	5	_	20a. Method of Disposition  1 X Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	Removal from State	Ob. Place of Dispos	sition (Name of natory or other place	:e)	Date 200	ederick, M	own, State
Daltimo	once.		21. Signature of Funeral Service Licens	2				ney and Bareet, Fred	sford Fun	•
Proysici			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition	ications that caused the ne cause of each line.			g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
68760, ifficate be executed Exam ig physician and as the burial Hansil	ner	LYallin	Sequentially list conditions, if any, leading to immediate cause. Ener Unueriphing Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor  Due to (or as a cor  Due to (or as a cor  Due to (or as a cor	enosis nsequence of):					
death cer e attendir	page 2 strang by Obyesters and Man	_	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year
he law requires that the has been signed by the conditions and the conditions are the conditions.	0 >4 20	r for mon	Part II. Other significant conditions cor Hypertension, Chr				en in Part I.	23e. Did tobacc	co use contribute to th 2 X No 3 ☐ Prob	ably 4 Unknown
The law ate has b	ola and o	-						24a. Was an autopsy performed 1 Yes 2 🔼	prior to cor	osy findings available inpletion of cause of
Or Vical Physician: T	a a	3	25. Was case referred to medical examiner?	lospital:	- 57-510	Othe		th (Check only one)		
3 0 = 0	5		1 Yes 2 X No  27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient  28a. Date of Injury (Month, Day Yea	2 ER/Outpatient 28b. Time of Injury	28c. Injury Work	at	ome 5 🔀 Residence 28d. Describe how in		()
	Certification.		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp.	At home, farm, stre	et, factory, office		28f. Location (Street City or Town, St	and Number or Rura ate)	l Route Number,
the Hospital or hin 24 hours afte the Funaral Dir	Modical		29a. Certifier (Check only one) 1 ★ Certifying Phys 2 ■ Madicel Examin	sician: To the best of my nar: On the basis of exar and manner stated.	knowledge, death nination and/or inve	occurred at the timestigation, in my op	e, date and place, pinion, death occur	and due to the cause red at the time, date a	e(s) and manner as stand place, and due to	ated. the cause(s)
To ti Within To ti	×	1	29b. Signature and title of certifier Cuyeal B.	(asay-	unde	29c. License			Date signed (Month, L	Day, Year)
9		- 1	30. Name and address of person who co Eugene B. Casagran				rederick			
Ren	State		31. Date filed (Month, Day, Year)	32. Registrar's S		Continue				

			1- State of Maryland / Dep	eartment of Health and Mertificate of Death		giene Reg. No 005	17253
	Physici	an	Decedent's Name (First, Middle, Last)     Emily R. Gooding		2. Date of Dea Month	Day Year	3. Time of Death
}	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	May 4,	2005 4c. County of Death	3:53 P M
	Funeral		Holy Cross Hospital  5. Social Security Number  6. Sex 7. Age (In yrs. last birthday)	Silver Spring    If Under 1 Year   If Under 24 Hrs.     Months   Days   Hours   Min.	8. Date of Birth (Month, Day	(Year) Cou	place (State or Foreign
	Director		217-42-8553         88         Yrs.           Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or L	ocation	Aug. 26	, 1916 Penn	10d. Inside City Limits
	r 28a-f eh	Director	Maryland Montgomery Si  10e. Street and Number	lver Spring	1	10g. Citizen of What Cou	1 ☐ Yes 2%☐ No untry?
	ath with		2307 Dexter Avenue	20902			USA
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inspectent: If Item 27 is marked other then "natural; or itema 23e or 28e-f ehow amy injury or pither treumatic event, the Medical Exemitar must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.
Maryland 21215-0036	within 72 ho ane. then "natur	Completed	(Specify only highest grade completed) (Given Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ing	16b. Kind of Business/li	ndustry
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ylar	Menta Arked arked	To B	John Rybnikar	Susan P	razenka		
Mar	d 2 sho th and 7 is m treum		19a. Informant's Name/Relationship (Type, Print)  19b. Mail  Dale McDaniel/ Executor of Will  547	ing Address (Street and Number or Rura			
lore,	it of Heali		20a. Method of Disposition  1 🖾 Burial 2 Cremation 3 Removal from State	osition (Name of matory or other place) May 2	ete 25,	20c. Location - City or T	own, State
Baltimore,	permit. Pa Departmer Importent any injury once.			National Cemetery 200 2 Name and Address of Facility is 200 University Blvd		Arlington,	_
L			23a. Pan1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ster the mode of dying, such as cardiac of			Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)  Cardiac Arrhythm:  Cardiac Arrhythm:	La			
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8760,	icate be executed physician and s the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):				
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O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	rery Day Year
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Vital	rsician: Th	o Be	25. Was case referred to medical examiner?  1 □ Yes 2 ☒No  Hospital: 1 □ Inpatient 2 ☒ ER/Outpatie	26. Place of Death			
Division of	To the Hospitel or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certifica completely filled in by the funeral director,	-	27. Manner of Death  1 XNatural 5 Pending (Month, Day Year)  28a. Date of Injury (Month, Day Year)  28b. Time of Injury	TIL 3 DOX 4 Nursing Hor		ence 6 □Other (Speci ow injury occurred	fy)
DIVIS	itei or Atters after de ai Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (St. City or Town	reet and Number or Run n, State)	al Route Number,
	the Hospi in 24 hou the Funer npletely fill	Medical	29a. Certifier  (Checy one)  1   Certifying Physicien: To the best of my knowledge, deat  2   Medicel Examiner: On the basis of examination and/or in  and manner stated.	nvestigation, in my opinion, death occurre	and due to the ca ed at the time, da	ause(s) and manner as s ate and place, and due t	stated. o the cause(s)
ı		2	29b. Signfatured and title of certifier	D25085	29	9d. Date signed (Month,  May 6, 200	
			30. Name and address of person to completed cause of death (Item 23a) (Type, Penny L. Bisk M.D. 10301 Georgia	•			
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 0 2005  32 Registrar's Signature	Avenue, Silver Sp	ering, M	u 20902	

State of Maryland / Department of Health and Mental Hygiene []

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			1 - State Registrar			•	Ce	rtific	ate of I	Death			Reg. N	lo.		1609
	Dhyois		1. Decedent's Nam	e (First, Middle	, Last)					_		2. Date of D	eath			3. Time of Death
	Physici /Medi		SONNY			GOL	AN							005 Yea	ar	10:35a <sup>M</sup>
}	Examir				, give street and nu			4b. (	City, Town, or	Location	of Death			c. County of D	eath	
			SHADY GRO		ENTIST HO	SPITAL			R	OCKV					MON	TGOMERY
	Funeral		5. Social Security N		6. Sex 1 ☐ M 21☑ F	7. Age (In yrs	. last birthday)	If U	nder 1 Year ths Days	If Under Hours	24 Hrs.	8. Date of B Month D 08/25/	irth Day Yea	9.1	Birthplac	ce (State or Foreig
	Director		219-19-69		10 M 2 <b>K</b> JF		57 Yrs.		,-	1100.0		08/25/	194	7 G	ERM	ÁNY
	pue *		Usual Residence of	10b. County		10c C	ity, Town or Lo	ocation								
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	iter d	Ë	11. Marital Status	ied 2[X]Marrie	Armed Fe	orces?	J.S. 13.	If Yes,	ecedent of Hi specify Cuba	ispanic Or in, Mexicai	igin? (Spec n, Puerto F	city Yes or N lican, etc.)	lo-	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>		
21215-0036	irs af	by F	3 Widowed		If Yes, Gi	ve		1 🗆 Ye	s 2 No	Specify:				Specify:	WHI	LTE
ğ	ature	ed		15. Decedent			16a. Dece	dent's t	Jsual Occupa	ation			16h	Kind of Busine	on/Indus	ntn.
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ğ	othe	Be C	17. Father's Name	(First, Middle, L	ast)						er's Name	(First, Middle	e, Maide	n Sumame)	TIATI	11(1)11
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Maryland	2 should be filed withir and Mental Hygiene. Ie marked other then eumatic event, Ire M	_	19a. Informant's N	ame/Relationsh	ip (Type, Print)		19b. Mailir	ng Addi	ress (Street a					or Town, State	. Zip Co	ode)
	t and 2 Health a em 27 ic		ZEEV GOLA	N/HUSBA	AND		9501	MAI	RY KNO	LL CC	OURT,	ROCKV	ILLI	E, MARY	LANI	20850
ē,	f Hearlitern		20a. Method of Dis				Place of Dispo	sition (	Name of		Da	ite	20c. l	Location - City	or Town	n, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 ie marked other then "naturel", or items 23e or 28e-1 show empty injury or other treumatic event, if a Madical Examinar must be notified at ODGS.		1 ☑ Burial 2 1 ☐ Donation		3 □Removal from ecify)		cemetery, crer. RDEN 0.				5/8/3	2005	CLA	AKCRIID	C N	1ARYLAND
=	permit. Page Department of Importent: if eny injury or once.		21. Signature of Fu										1		G , I.	IMITIAND
m	Depar Impor eny ir		X 101	Rest it	<i>†</i> >		El	DWAI	RD SAG	EL FU	MERAI	DIRE	CTIC	ON, INC.		TD 00050
			23a. Part1. Enter t	t1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.											ND 20852 pproximate	
	Dharisian		Immediate Cause	snock, or heart failure. List only one cause on each line.									In	terval Between nset and Death		
	Physician /Medical		disease or condition resulting in death)	in	a.	LRATORY (or as a consec		RE							1	WEEK
	Examiner				quence of): PHALOPA	A TIIT	7							D 4 **		
		ē	Sequentially list co	nditions, nmediate	D	(or as a consec		AIUI							1	DAY
	t Insit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	rlying injury		RICULAR		T. A.T.	TTON							
	and and all tra	xa	resulting in death)	Last	C	(or as a consec									-	
68760,	sicla bur	cail		- 1	d	d										
89	ertificate be executed ding physician and se as the burial-transit	Medicai			- G.										-	
Xo	eath certificate be executed attending physician and for use as the burial-transit	2	IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes, out	tcome of pregn								23d. Date of d	leliven	
m	The law requires that the death cate has been signed by the attencage 2 should be detached for us	Physicia	in the past 12 1 Yes 2	months?	4 ☐ Pregr	oirth 2 ☐ Feta nant at time of c			c pregnancy (specify)					Month	Da	y Year
0	that the de led by the detached	hys	9 □ Unknown		9□ Unkn	own										
٥.	that ned to det	by P	Part II. Dther signif	icant condition	s contributing to d	eath but not res	sulting in the ur	nderlyin	g cause give	n in Part I.		23e. Did	tobacco	use contribute	to the c	cause of death?
Records,	quires n sign uld be											10	Yes 2	2 □ No 3 □	Probabl	y 4 🖫 Unknown
Ö	w requires been si should I	jete										24a. Was	2 20	24h Were	autoneu	findings sysilable
Re	The lavate has	Completed										auto		prior to	compl	findings available etion of cause of
Vital			25. Was case refer	rad to madical								1 ☐ Yes	2 <b>X</b> N		s 2[	□ No
₹	Physicien: this certific al director,	o Be	examiner?		Hospital:		1500		DOA Cthe	_		Check only				
o		To L	27. Manner of Deat		1 1 1 1		ER/Outpatien	3_	DOA	4 🗀 1401		d. Describe		6 ☐ Other (Sp	ecify)	
Division	ding h. After funer	tior	1 XNatural	5 Pending investiga		of Injury th, Day Year)	Injury	М	28c. Injury Work	? es 2□N		d. Describe	now mije	ny occurred		
S	or Attending after death. Director: Afte in by the fune	Certification;	2 Accident 3 Suicide	6 ☐ Could no	ot be	of Injury - At h	ome farm stre			03 2		f Location /	Street 2	nd Number or I	Dural D	auta Alumba s
$\stackrel{>}{\sim}$		erti	4 Homicide	determin	buildi	ng, etc. (Specil	fy)	ot, Iaci	lory, office		20	City or To	wn, Stat	B)	HUTAI H	oute Number,
2	Hospitel or 24 hours afte Funerel Dir tely filled in		29a. Certifier	1X Certifying	Physician: To the	he st of my kno	awledge dooth		and and the stimus			al atom a state of		\		
P	a Hospite 24 hours Funerel etely filled	Medical	(Check only one)	2☐ Medical E	Adminut: On the ba	asis of examina	ation and/or inv	estigati	on, in my opi	e, date and inion, deat	h occurred	a due to the lat the time,	date an	d place, and du	e to the	d. e cause(s)
	To the Hospitel or within 24 hours after to the Funerel Dir completely filled in	Me	29b. Signature and	title of certifier				1	29c. License	number			29d. Da	ite signed (Mor	nth, Dav	/, Year)
)	1 /		1/-	112					D0061					6, 200	-	/
•	6		30. Name and addr	acc of navana	to complete d an	o of docub (It	n (22a) /T	Date 42								
			DR. ROBER	T KIRKC	ho completed caus ALDY, 99(	)1 MEDI	CAL CEN	-rint) ITER	DRIVE	E, RO	CKVIL	LE, MA	ARYI.	AND 20	850	
	Sta		31. Date filed (Mon			egistrar's Signa										
•	Registr		M	AY 10	2005	4.00 0	ture do	342	D							

			1 = For State Registrar	State of Maryla		artment of I		l Mental Hy	giene	0000	17000
			1. Decedent's Name (First, Middle, Last)					2. Date of De Month		in UU	3. Time of Death
	Physici /Medic		Nona Godet					May 8		05	1:10 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of De	ath	40	. County of Dea	th
			Casey House			Rockvil.				lontgome	
	Funeral		5. Social Security Number 6. Sec	7. Age (In yr ] M 2127 F	s. last birthday)	Months Days	If Under 24 H	in. (Month, D	rth ay, Year)	9. Bir	thplace (State or Foreign ountry)
	Director		199-18-5895 Usual Residence of Decedent	- A	76 Yrs.			08/22/	1928	Per	nsylvania
	land bw		10a. State 10b. County	10c. (	City, Town or L	ocation					10d. Inside City Limits
	Mary -1 sh	to	MD Montgome	ry C	hevy Ch	ase					1∰ Yes 2 □ No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Cit	tizen of What C	ountry?
	h witi	a D	4701 Willard Aven	ue #708		20815			U.	S.A.	
	deat	Funeral		12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	tispanic Origin?	(Specify Yes or N	0-	14. Race - Am	
9	or Ite	/Fu	1 ☐ Never Married 2 Married	1 ☐ Yes 2 📉 No If Yes, Give		1 ☐ Yes 2 ☒ No	Specify:	orto i mozri, oto.)		Black, Whi	
8	ural',	d by	3 Widowed 4 Divorced	Year or Dates:						WI	ite
<u>.</u>	within 72 hours after death with the Maryland ena. than "natural", or Items 23a or 28a-1 show ra Madical Evartiret masi ke Indilliad al	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	ation during most of v	vorking	16b. K	and of Business	/Industry
7	withlr ena. than	m d m	Elementary/Secondary (0-12)	College (1-4or 5+)		Estate A			R	eal Est	ate
2	filled Hygi ther ant, I	ပိ	17. Father's Name (First, Middle, Last)	<u>+</u>	Rear	notate m	Ť ·	lame (First, Middle			
<u>a</u>	ld ba ental ked (	To Be	Harry Lovich				Sara H	Belis			
Maryland 21215-0036	shound M	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ing Address (Street			er, City	or Town, State,	Zip Code)
Σ	and 2 alth a 127 l		Leonard J. Godet,	Husband	4701	Willard A	Avenue 4	708, Che	vy C	hase, M	D 20815
Baltimore,	permit. Pagas 1 and 2 should ba filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or giber treumetic event, the Medical Examinet mast be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ F	20b	. Place of Disponentery, cre	osition (Name of matory or other pla	ce)	Date	20c. L	ocation - City or	Town, State
<u>Ĕ</u>	Paga ment ant: I		'4 □ Donation 5 □ Other (Specify)	F	t. Linc	oln Crema	tory 05	/12/2005	Bre	ntwood,	Maryland
ä	eparti eparti port ny inj		21. Signature of Funaral Service Doens	· 1) 4		2. Name and Addre		-			
_	70 E 8 9		hoully te	an Willy						e, Mary	1and 20852
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	ne cause on each line.	eath. Do not en	ter the mode of dyi	ng, such as card	iac or respiratory a	arrest,		Approximate Interval Between Onset and Death
ì	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Amyotroph		ral Scle	rosis				12 months
ľ	Examiner			Due to (or as a cons	equence of):						
		er	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	Due to (or as a cons	ечивпов об).		-				
	utad d ansit	Examiner	Cause (Disease or injury that initiated events								
Ó	an ar	EX	resulting in death) Last	Due to (or as a cons	equence of):						
3760,	The law requiras that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Ilcal		J							
39	leath certifica attending ph I for use as tl	Med	IF FEMALE:								
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1☐Live birth 2☐Fe	etal death 3	Ectopic pregnanc	y		1	23d. Date of de Month	livery Day Year
o Ö	at the de by the a stachad f	Physician/M	1 ☐ Yes 2 🏹 No 9 ☐ Unknown	4∐Pregnant at time o 9⊡Unknown	rdeath 5t	Other (specify)					
<u>α</u>	ras that ti igned by be detac		Part II. Dther significant conditions con	ntributing to death but not r	esulting in the u	underlying cause giv	ven in Part I.	23e. Did	tobacco	use contribute t	the cause of death?
Records,	uiras n sign ld be	d by						1 🗆	Yes 2	XNo 3□P	robably 4 Unknown
00	w require been sign should b	Completed						24a. Was	an	24b. Were a	utopsy findings available
æ	he lav e has age 2	duc			-				ormed?	death?	completion of cause of
ta	ding Physicien: The Ih. After this certificate ha	a	25. Was case referred to medical				26. Place of D	1 ☐ Yes eath (Check only		1 Yes	2 □ No
Division of Vital	Physicien: r this certifica ral director,	To B	examiner? 1 ☐ Yes 217 No	lospital: 1   Inpatient 2	☐ ER/Outpatie	nt 3□ DOA Ott				6 XIOther (Spe	cify) Hospice
0	ng Ph ter th neral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o		ry at	28d. Describe			
Siol	Attending r death. sctor: After by the fune	catle	2 Accident investigation				Yes 2 □ No				
Ĭ		ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	thome, farm, st cify)	reet, factory, office		28f. Location ( City or To			ural Route Number,
7	Hospitel	0	00a Cadifica 1M Cadifair - Ph.				4-1	1			
4	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a, Certifier 1 A Certifying Physical Check only 2 Medical Exami	sician: To the best of my k ner: On the basis of exami and manner stated.	ination and/or in	in occurred at the till nvestigation, in my o	me, date and pla opinion, death of	ce, and due to the curred at the time,	date and	d place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title/of certifier			29c. Licens	se number		29d. Da	te signed (Mon	h, Day, Year)
)	1		1 tames	Donly	4	D202	297	langur substitution	Mav	9, 200	5
	6		30. Name and address of person who co	empleted cause of death (II	tem 2 a) (Type						
			James Brodsky, MD,				evy Chas	se, Maryl	and	20815	
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 0 2005	Registrar's Sig	nature And	JE)					
	Tay all as I	221	(VI FA 1   1 17 / 1 11 1	I WINDOWS AND A SE	HOLD BEEN STREET	The same of the sa					

			1 - For State Registrar	State of Marylan	-	artment of F			iene	15 17000
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
	Physici /Medic		Mary Jacqueline (	Gleason				May 8,		9:00 P M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of De	ath	4c. County of I	Death
			10225 Frederick			Kensing			Montg	omery
	Funeral		5. Social Security Number 6. Sec	TM 2KTE	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	n. (Month, Day	Year)	Birthplace (State or Foreign Country)
١.,	Director		Usual Residence of Decedent	79	115.			Dec. 13	, 1925 M	assachusetts
	land ow		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Mary fied	ţō	Maryland Me	ontgomery		Kensi	ngton			1 ☐ Yes 2 No
	r 28a	rec	10e. Street and Number			10f. Zip Code	ing com	1	0g. Citizen of Wha	at Country?
	3a o	J D	10225 Frederick A	venue, #312			20895		Ū	SA
	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28a-f show t.s. M. offel Examiner must be multified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H	lispanic Origin?	(Specify Yes or No- erto Rican, etc.)		American Indian,
9	or Ite	/Fu	Never Married 2☐ Married	1 ☐ Yes 2XXNo If Yes, Give		1 ☐ Yes 2 🎦 No	Specify:	orto ritoari, etc.,	Specify: W	White, etc. Nhite
8	ural',	d by	3 Widowed 4 Divorced	Year or Dates:					эрвину.	
21215-0036	nati	Completed	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occup kind of work done	during most of w	rorking	16b. Kind of Busin	ess/Industry
72	withir sne. than	шр	Elementary/Secondary (0-12)	College (1-4or 5+) 5 +		DO NOT use retired	,	G3:1		
2	Hygie ther		17. Father's Name (First, Middle, Last)	JT	Medica	r mergency		Coordinato		al Government
and	d be	Be c	Frederick James	Gleason				n Theresa	,	11
<u></u>	mark mati	P	19a. Informant's Name/Relationship (Ty		19b. Mailir	a Address (Street		Rural Route Number		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury open traumatic event, It a Madical Examinat must be notified at once.		Frederick J. Gleas	son/ Brother				elphi, Ma		
ē,	f Hea f Hea ftem ftem		20a. Method of Disposition		Place of Dispo	sition (Name of matory or other place			20c. Location - Cit	
Baltimore,	Page ento		1 Burial 2 □ Cremation 3 □ R  '4 □ Donation 5 □ Other (Specify)	removal from State		ven Cemeter			Silver S	pring, Marylan
Ħ	oartm sorta / inju		21. Signature of Funeral Service License	9	22	Name and Addre	ss of Facility	s Funeral		
Ö	Departiment of the second of t		Kobert C/Ca	emily	5	00 Univer	sity B1	vd, W, Si	lver Spr	ing, MD 20901
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	ications that caused the deat	h. Do not ent	er the mode of dyir	ig, such as card	ac or respiratory arr	est,	Approximate Interval Between
	Pnysician:		Immediate Cause (Final disease or condition	, Breast Cance	er (Ri	th+)				Onset and Death  3½ Years
	/Medical		resulting in death)	Due to (or as a conseq		inci				J <sub>2</sub> rears
	Examiner	L	Sequentially list conditions,	b						
	ad sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):					
	ecute and I-tran	хаш	cause. Enter Underlying Cause Obsace of high that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
8760,	ate be executed hysician and the burial-transit			245 10 (0) 43 4 00/1364	uence or <sub>j</sub> .					
	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edicai		d						
9 X	death certifica attending ph d for use as ti	/Me	IF FEMALE:	23c. If yes, outcome of pregna	ancv				23d. Date o	f delivery
Вох	atter for u	ciar	in the past 12 months?	1 Live birth 2 ☐ Feta 4 Pregnant at time of d	Ideath 3□	Ectopic pregnancy Other (specify)	,		Month	Day Year
o.	at the death certi I by the attending stached for use a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		2 (-)//				
<u>α</u>	res that igned b be deta	by P	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tol	bacco use contribu	te to the cause of death?
Records,	quire n sig uld be	d b	Anemia					1 🗆 Ye	es 2 <b>X</b> No 3[	Probably 4 Unknown
00	aw requir as been si 2 should	olete						24a. Was a	n 24b. Wer	e autopsy findings available
Re	The lay te has age 2	Completed						autops perforr 1 ☐ Yes	ned? dea	r to completion of cause of th? Yes 2 \sum No
Vital		0	25. Was case referred to medical				26. Place of D	eath (Check only on		165 20110
	Physician; r this certific ral director,	o B	examiner? 1 Yes 2 No	lospital:	ER/Outpatien	at 3□ DOA Cth		Home 5 A Reside		Specify)
0	ding Phy h. After thi funeral	T: T	27. Manner of Death  1   Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of				ow injury occurred	
<u>.</u>	Attending r death. ector: After by the funer	atlc	2 Accident investigation				Yes 2 □ No			
Division of		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str	eet, factory, office		28f. Location (St City or Town		or Rural Route Number,
	itafo rrs af ral D							1		
\$	To the Hospitat or within 24 hours after To the Funeral Dir completely filled in	edical	(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina	wledge, death tion and/or in	n occurred at the tir vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the ca curred at the time, d	ause(s) and manne ate and place, and	er as stated. due to the cause(s)
	To the within 2 To the complet	Med	one)	and manner stated.		29c, Licens	e number	2	9d. Date signed (A	Annth Day Year)
	To		29b, Signature and title of certifier	Coupled			02338		May 9,	
7	12				- 03a) (T					
	-		30. Name and address of person who con Richard P. Delane				Whea+	on , MD 20	1906	
	Sta	te	31. Date filed (Month, Day, Year)				, wileac	OII , FID Z	300	
	Registr		MAY 1 0 200	37 Registrar's Signa	Carrie	Ma				

				State of M		partment of			_	
		•	For State Registrar		•	ertificate of			Reg. No. 200	15 1725
PI	hysicia	an	Decedent's Name (First, Middle, Last					2. Date of De Month	Day Ye	ar 3:30 A M
	/Medic xamin		Joseph David He  4a. Facility Name (If not institution, give	nry street and number)		4b. City, Town,	or Location of D		4c. County of D	
-	ханин	EI	~	Jursing	Home	Boon	sboro		Wast	sington
Fu	neral		Social Security Number     6. S	9x 7. Ag	je (In yrs. last birtho	Months Davs		Hrs. 8. Date of Bir Min. (Month, Da	th 9.	Birthplace (State or Foreign Country)
Dir	ector		079_05_5484 Usual Residence of Decedent	LW ZUF	90 Yr	s.		April	26 1915	New York
land	M W	1	10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
Man	ified	tor	Maryland Washir	iton	Boonsbo	oro				1 ☐ Yes <b>※</b> ☐ No
hours after death with the Maryland	"naturel", or Rems 23e or 28a-1 show dical Examiner must be notified at	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	t Country?
ath wi	23e		8507 Maplevil				713		United	
er de	Rems Der T	Funeral	11. Marital Status 1 ☐ Never Married 2 Married	12. Was Decedent Armed Forces	)	<ol> <li>Was Decedent of If Yes, specify Cu</li> </ol>	Hispanic Origin ban, Mexican, F	17 (Specify Yes of No Puerto Rican, etc.)		American Indian, Vhite, etc.
irs aft	P E	by F	3 Widowed 4 Divorced	1 ☐ Yes ♣☐ If Yes, Give Year or Dates:	.,,	1 ☐ Yes 2 🗶 No	Specify:		Specify:	White
KIKID-UUSO od within 72 hours af gjene.	ature Ical E		15. Decedent's Ed (Specify only highest gra	ducation	16a. D	ecedent's Usual Occu	upation	f working	16b. Kind of Busine	ess/Industry
within 7	r than "natu the Modical	Completed	Elementary/Secondary (0-12)	College (1-4or		fe. DO NOT use retir	ed)			
filed w Hygier	other th		47 Februar Name /First Middle Last	4		Civil	Enginee:	Name (First, Middle		ction Company
ylaric ould be fi Mental H	2 2	Be	17. Father's Name (First, Middle, Last) Lesley David He					lizabeth M		
Maryland d 2 should be file th and Mental Hy	marke matic	ဥ	19a. Informant's Name/Relationship (		19b. N	Mailing Address (Stree			er, City or Town, Sta	te, Zip Code)
and 2 seath ar	9 8		Michele Stromber		aughter)2	873 Conste	ellatio	n Finksbu	rg Maryla	nd 21048
es 1 and 2 of Health			20a. Method of Disposition		20b. Place of D	isposition (Name of crematory or other pi		Date	20c. Location - City	or Town, State
n o o .	= 5		1 ☐ Burial 2 <b>X</b> Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specification)			urg Cremat		ay 10, 05	Smithsbu	rg Maryland
bartimo permit. Pag Department	Importent: any injury 2058.		21. Signature of Funeral Service Licer	isee 07		22. Name and Add	ress of Facility	Douglas A.	Fiery Fu	neral Home
<b>a</b> 88.	트롭혀		/ Dunglest	Ten	4	1331 East	tern Bly	vd. N. Hac	erstown M	aryland 2174
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that cause one cause on each	dthe death. Do no line.	t enter the mode of d	ying, such as ca	rdiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	sician	1	Immediate Cause (Final disease or condition resulting in death)	a. Collo	on Ca	ucey				2×
	edical miner		resulting in death)	Due to (or as	s a consequence of					1
		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	s a consequence of	):				
petr	ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events							
ou, be executed	rsician and e burial-transit	Exa	resulting in death) Last	Due to (or as	s a consequence of	):				
te be e	iysicia ne bul	icai		_ d						
Records, P.O. Box 687 The law requires that the death certificate	attending physi I for use as the b	Physician/Medic	IF FEMALE:						P== 1	les emerces and a more
BOX	ttendi or use	lan/l	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐Ectopic pregnar	псу		23d. Date of Month	f delivery Day Year
. a	the a	/sic	1 Yes 2 No	4∐Pregnant a 9☐Unknown	at time of death	5 Other (specify)				
D. D. O. That the	signed by the a		Part II. Other significant conditions	contributing to death	but not resulting in t	he underlying cause of	given in Part I.	23e. Did	tobacco use contribu	te to the cause of death?
d Signal	og pl	d by						1 🗆	Yes 2□No 3□	☐ Probably 4 KajUnknowr
Records,	s peen s	Completed						24a. Was	an 24b. Wer	e autopsy findings available
ਜੂ ਭੂ	ate has page 2 s	шо						— auto perf 1 ☐ Yes	ormed? deal	r to completion of cause of th? Yes 2 □ No
Of Vital Physiclen: T	certificate rector, pag	a	25. Was case referred to medical				26. Place o	of Death (Check only		
OT VITAL	nis ce I direc	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1  Inpat	ient 2 ER/Outp	patient 3 DOA	Other: Nurs		idence 6 Other (	Specify)
<b>E</b> 5	After this funeral di	on:	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Inj (Month, D	ury 28b. Tii ay Year) Inj	ury W			how injury occurred	
Division for Attending after death.	the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not be		nium. At home farr		Yes 2 No		(Street and Number o	or Rural Route Number,
or At	Direc in by	artif	4 Homicide determined	289. Place of it	etc. (Specify)	n, street, factory, offic	æ	City or To	wn, State)	in ribital ribital ribital
DIVISIO  To the Hospitel or Attendit within 24 hours after death.	To the Funerel Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying P	nysician: To the bes	t of my knowledge,	death occurred at the	time, date and	place, and due to the	cause(s) and manne	er as stated.
he Ho	he Fu	Medical	(Check only 2 Medical Exa	miner: On the basis and manner s		or investigation, in m	y opinion, death	occurred at the time	, date and place, and	
To the	To the comp	Σ	29b. Signature and title of certifier		$\supset$	29c. Lice	ense number		29d. Date signed (A	**
				nos		1)	5232	3	5/8/0	7
<i>5</i> H-3			30. Name and address of person who	completed cause of	death (Item 23a) (T	ype, Print)	1 C+	Henove	tow. m	D. 21740
בדוג			31. Date filed (Month, Day, Year)	1 Wasc	trar's Signature	ab UFW	٠١٠	114yers	, , , , ,	
	Sta Regist	ate	NAY 11	2005	A.	Brankes				

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

			For Stata Registrar	State of Maryl		tificate of L			eg. No.2 0	05	17258
ı	Physicia	an	1. Decedent's Name (First, Middle, La					2. Date of Death		Year	3. Time of Death 3:45 A M
	/Medic	al	Randy  4a. Facility Name (If not institution, giv	DePrei	st	Howard	Location of Death	rai 14,	4c. County	of Death	3:45 A M
	Examin	er	FREDERICK MEMORIA	AL HOSPITAL		FREDE			FREDE		CO
	Funeral Director		5. Social Security Number 6. S 219-02-7685 Usual Residence of Decedent	6ex 7. Age (In )	vrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 04/08/197	Year)	9. Birthi Coul Mary	
	/iand iow		10a. State 10b. County	10c.	City, Town or Lo	cation					10d. Inside City Limits
	e Mar	ctor	MD Washi	ngton	Hagerston	wn					1 ∑Yes 2 □ No
	vith th	Director	10e. Street and Number			10f. Zip Code		10	Og. Citizen of V	Nhat Cou	ntry?
	eath v	eral	428 Park Place	12. Was Decedent Ever	n U.S. 13. V	21740 Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-	USA 14. Rac	e - Ameri	can Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic evant, its Medical Examinational be notified at once.	Completed by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		f Yes, specify Cuba I□Yes 2∭ No		Rican, etc.)	Specify	ck, White, y:	etc. Black
Š	72 ho natur	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Give	lent's Usual Occupa	luring most of work	ing	16b. Kind of Bi	usiness/In	dustry
121	within ane. than "	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	00 NOT use retired Laborer	)		Cons	struct	i on
Maryland 21215-0036	filed t Hygie other	Be Co	17. Father's Name (First, Middle, Last	)		Laborer	18. Mother's Nam	e (First, Middle, N			1011
/lan	uld be Menta Mrked atic ev	ToB	Gary	Cannon			Vetie	Ве	atrice	Но	ward
lar.	2 sho		19a. Informant's Name/Relationship ( Terrance Howard / bi	**		g Address (Street a				State, Zij	Code)
e,	1 and Health		20a. Method of Disposition	20		Box 671, Fi sition (Name of natory or other place			.1332 20c. Location -	City or T	own, State
ē	Pages nent of I ant: If Its ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	THemoval from State		l Crematory	05/17	/2005	Cumber	·land.	Maryland
Baltimore,	permit. Departm Importa any inju		21. Signature of fune al Service Lice	1 See		Name and Addres					
			23a. Parti. Enter the disease, or com shock, or heart failure. List only	applications that caused the cone cause on each line.							Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	a Hue	tiple ]	Erjuri					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cor	isequence of):	0					
		er	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	b. Due to (or as a con	sequence of):					-	
	cuted nd ransit	Examiner	that initiated events	c							
60,	ificate be executed g physicien and as the burial-transit		resulting in death) Last	Due to (or as a cor	isequence of);						
68760,	ficate physics the l	edical		d				0.775.2	10.00		
Box	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pro 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				ite of deliv	ery Day Year
P.0	that thed by detact	/ Phy	Part II. Other significant conditions	contributing to death but no	resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use cont	tribute to I	he cause of death?
rds,	quires n signe	ed by						1 □ Ye	es 2 No	3 🗆 Prof	bably 4 Dunknown
Records,	The law require ate has been sig page 2 should b	Completed						24a. Was ar autops perform 1K Yes 2	y ned?		opsy findings available ompletion of cause of
Vital	Physiclan: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital	7.7	Oth		h (Check only on	e)		
of		<u>구</u>	1 XYes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury	28b. Time of		4   Nursing no	ome 5 Reside			cupantot
lon	Attanding r death. actor: After by the fune	atlon	1 □Natural 5 □ Pending 2 💢 Accident investigation	(Month, ay Yea	r) Injury	Worl	k? Yes 2 No	anmva			ing.
Division	r Atta	Certification:	3 Suicide 6 Could not to 4 Homicide determined	De 280 Place of Injuny -	At home, farm, str			28f. Location (St. City or Town	reet and Numb	er or Run	al Route Number.  Main St
	pital o		00- Cartifica 4 Gardifician B		oad war	and the time	an data and place	Mi	adleto	non	MP
	e Hose 24 ho a Fune etely f	edical		hysician: To the best of my minar: On the basis of exam and manner stated.							
	To the Hospital or Attanding Phys within 24 hours after death.  To tha Funaral Director: After this completely filled in by the funaral di	Me	29b. Signature and title of certifier	1		29c. Licenso	e number CME		9d. Date signe		
•	/		lard t	tallan 1	ud_			Į ľ	1AY 14,	200.	
	BRS		30. Name and address of person who	LAN		111 Pen	n Street	Baltimo	ore, Ma	ryla	nd 21201
	Sta Regist		31. Date filed (Month, Day, Year) MAY 18 200	32. Registrar's S	Signature	a de					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 2. Date of Death Month

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2005 010 /Medical Facility Name (If not institution, give street and number) Ab. City, Town, or Location of Death 4c. County of Death Examiner enter 1100 neste If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 16, If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1XM 2□ F Days 73 516-28-1927 MT Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or items 23a or 28e-f show the Medical Exercises must be notified at Director 1 ☐ Yes 2 X No Lancaster Lancaster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 248 Charles Road 17603 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Year or Dates: Specify: White 1 □ Yes 2 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Intelligence Military Hygi other treumetic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil tment of Health and Mental H tent: If item 27 is marked otf Be Edward J. Hay Harriet Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 248 Charles Road, Lancaster, PA 17603 Gloria Hay/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or Depertment of Joseph's Cemetery May 13, 2005 Bausman, PA 1 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licenses 'n Fellows, Helfenbein & NEwnam Funeral Home, 130 Speer Road, Chestertown, Maryland 21620 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or com shock, or heart failure. List only o como ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. one cause on STENDS15 Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Due to (or as a consequence of): **Examiner** MNDIO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed onsnan burial-tran and resulting in death) Last Due to (or as a consequence of attending physician Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No be detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy certificate 1 ☐ Yes 2 No Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 🗌 Inpatient 2 R/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending Injury 1 🗌 Yes 2 No death. 2 Accident investigation 24 hours efter deat Funerei Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitei 1 Conflying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) the within Signature and 29c. License number 29d. Date signed (Month, Day, Year) 0 2 no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registra

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

HESTERTOWN

SHA

32. Rec

TRICK 31. Date filed (Month,

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 8:45 P M May 6 2005 Arthur C. Huggins /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Sykesville Brinton Woods Nursing & Rehab Center Carroll If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country)
March 26,1909 Maryland Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F 96 217 03 9832 Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygliene. Important: If item 27 is marked other than "natural" or it. 10d. Inside City Limits 10b County 10c. City, Town or Location 10a. State 1 Yes 2 XNo MD Carroll Eldersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code ᅙ United States 6009 Crossway Court 21784 Funerai 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █No 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No If Yes, Give Year or Dates: Specify: þ White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Turbine Operator BGE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kathryn Ossmus James E. Huggins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6009 Crossway Court Eldersburg, MD 21784 Gordon Huggins/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 5-11-2005 Woodlawn Cemetery Baltimore, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 Coll 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ischemic Heart Disease > 1yr Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure > 1yr Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exan iner as the burial-transit The law requires that the death certificate be execuled and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death **esn** 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?

1 Yes 2 No for 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 No certificate has page 2 1 Yes Attending Physicien: funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) In by 4 | Homicide 0 filled Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mean D20806 5/8/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patrick Turnes, MD 1000 Liberty Road Eldersburg, MD 21784 32. Pogistrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 0 2005 Registrar Goods)

DHMH 17 Rev 1/2001

**ORIGINAL** 

Georgia L. Herbert Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-03300 Amend Item#5, peral GMasyland 965 account of Health and Mental Hygiene RJ 1- State Unpend Item 23a, pt.II, 27 per me 1996 at 6 073 205 to tas Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Georgia Lue Herbert 2005 May 12 09:15 p. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctors Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 □ F Months Days Hours 79 Director 8/8/25 Saluda, S.C. Usual Residence of Decedent the Maryland ehow. 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f eho: treumatic event, the Medical Examinat number a notified at Yes 2 No Director Md. P.G Capitol Heights 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1207 Nye Street 20743 Funeral U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: Completed by Specify: 3 XWidowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Coleman Dasil Coleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Emily B. Brown/Caretaker 1315 Chapel Oaks Dr., Capitol Hgts., Md. 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 0 permit. Page Department of Important: If any injury or once. Chesapeake Crematory, Inc. 5/16/05 Beltsville, Md <sup>4</sup> □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave. N.E. Washington, D.C. 20019 All 23a. Part1. Enter the disclase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a Hypertensive Atherosclerotic Cardiovascular Disease disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Diabetes Mellitus, Acute Psychosis 1 ☐ Yes 2 🛛 No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☑ No 24a. Was an autopsy performed? 2□No 1 X Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one)

After

Certification: To

Medica

Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Southall, MD

111 Penn Street Baltimore, Maryland 21201

May 13, 2005

State Registrar

31. Date filed (Month, Day, Year) MAY 1 8 2005

ramela

2. Registrar's Signature

4 | Homicide

within 24 hours after death To the Funeral Director:

			State of Maryland / Department of Health and M  State of Maryland / Department of Health and M  Certificate of Death		ene g. No. 005	17262
1	Physicia		1. Decedent's Name (First, Middle, Last) Olivia Y. Hughes	2. Date of Death		3. Time of Death 1:10 AM <sub>M</sub>
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death	-10
	Funeral		Beclin Nucsii grande Perboli I tation (enter Perlin Description of the	8. Date of Birth (Month, Day,		place (State or Foreign ntry)
	Director		219-07-0092-A S9 Yrs.  Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	Feb 05	1916 150	10d. Inside City Limits
	e Maryla ta-f sho	ctor	MD Worchester Berlin			1 XYes 2 No
	se or 28	i Dire	10e. Street and Number 10f. Zip Code 21811		g. Citizen of What Cou	ntry?
	itams 2	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes 2 No  1 Never Married 2 Married 1 Yes 2 No	ecify Yes or No-	14. Race - Ameri Black, White	
Y 215-0036	n 72 hours after death with the Marylar "natural", or items 23s or 28a-f show spiral Examilier man be malified at	by	3 ★ Widowed 4 □ Divorced   If Yes, Give Year or Dates: 1 □ Yes 2 ★ No Specify:		Specify: B	ach
¥215-	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I marked other than "natural", or items 23s or 28a-f show umatic avant, the Modical Exemilier mant to mullike at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	ing 1	6b. Kind of Business/Ir	dustry
ia 1d 21	ould be filed with Mental Hygiene arkad other tha atic avant, II e	Be Cor	17. Father's Name (First, Middle, Last)  Blouse Pressec  18. Mother's Name	e (First, Middle, M		Taher
Olivia Maryland	2 should be filed withir and Mental Hygiene. Is markad other than aumatic avant, Ite M	To E	Frank MCGracocy  19a. Informant's Name/Relationship (Th., Prin.)  19b. Mailing Address (Street and Number or Rura	e Mc Gr	COTY State Z	Codol
	es 1 and 2 sho of Health and I itam 27 Is m r othar traum		I range E Duffy 9614 Mary Bood Ber	lio, MD	21311	
Hughes, Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygtene. Importament of Health and Mental Hygtene. Important: if item 27 is marked other than "natural", or items 23s or 28a-f sho amy injury or other traumatic event, if a Madical Examinating must be multilised at anny injury or other traumatic event, if a Madical Examinating must be multilised at annexes.		Burial 2 Cemition 3 Removal from State	14 ZÔS F		own, State
Hug	permit. Pages Department of Important: If i any injury or once.		21. Signatury of Funer Il Service Lie nisee  22. Name and Addr ss of Facility  3.09 F-(1.54)	eral H	ene	163
	÷		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac a shock, or heart failure. List only one cause on each line.	or respiratory arres		Approximate Interval Between Onset and Death
D	Physician / /Medical	į.	Immediate Cause (Final disease or condition resulting in death)  A Meta-fectic Lune Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	ice/		Years.
	Examiner	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence or):			
	xecuted and al-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence or):  c.  Due to (or as a consequence or):			
8760,	icate be executed physician and s the burial-transit	edicai E	d			
Box 6		an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of deliv	•
P.O. F	t the dea by the al	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Other (specify)		Month	Day Year
	law requires that the death certif as been signed by the attending 2 should be detached for use a	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to	1
Division of Vital Records,	2 38 2	Completed		24a. Was an autopsy perform	prior to co	opsy findings available impletion of cause of
Vital		Be	examiner?	1 Yes 2	1 Yes	2□ No
n of	ding Phys. h. After this of funeral dir	on; To		me 5 Resider 28d. Describe hov	nce 6 Other (Speci w injury occurred	(y)
/islo	Attending Physician: r death. sctor: After this certific by the funeral director,	Certification;	2 Accident investigation 3 Suicide 6 Could not be editermined determined	28f. Location (Stre	eet and Number or Rur	al Route Number,
Ö	pital or ours afte aral Dire		building, etc. '(Specily)  29a. Certifier  1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	City or Town,		And a d
	To the Hospital or Attending Ph within 24 hours after death. To tha Funaral Director: After th completely filled in by the funeral	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	red at the time, dat	te and place, and due t	o the cause(s)
	To COI		29b. Signature and title of certifier  Crecellul D 2856	7	d. Date signed (Mgnth,	Day, Teal)
C.t	1.3		Mammind address of person who completed cause of death (Item 23a) (Type, Print)	Staf 1	1000	19944
	Sta Registi		31. Date filed (Month, Day, Year)  MAY 1. 0 2005  32. Degistrar's Signature			,

			State of Maryland / Department of State of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate o		, ,	OBBE	
			Registrar  1. Decedent's Name (First, Middle, Last)	Death	2. Date of Death	. No./	3. Time of Death
	Physici		Kathleen Ruth Higdon		Month May	6, Year 2005	1:00 P. M
	/Medio Examin			n, or Location of Death	IIdj	4c. County of Death	
ı			107 Oakton Road Gai	thersburg		Montgome	erv
	Funeral		Months Day	ar If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	9. Birth	place (State or Foreign
	Director		579-32-0184 78 Yrs.  Usual Residence of Decedent		June 29,		PA
	land ow		10a. State 10b. County 10c. City, Town or Location			T	10d. Inside City Limits
	Mary -1 sh	ţo	Maryland Montgomery Gaithersburg				1X Yes 2 No
	with the Marylands or 286-1 show	Directo	10e. Street and Number 10f. Zip Code	9	10g	. Citizen of What Cou	intry?
	h with	ai D	107 Oakton Road 208	177		USA	
	ter deal	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of	of Hispanic Origin? (Spo uban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri	
Š	or It		1 Never Married 21X Married 1 □ Yes 2 1X No		riodii, otc.;	Black, White	, etc.
ğ	filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or Iteme 23a or 28e-1 show ont, the Modical Examitar must be molified at	d by	3 Wildowed 4 Divorced Year or Dates:			W	nite
,	n 72 "nat	Completed	life DO NOT use ret	ne during most of works	ing 16	b. Kind of Business/Ir	ndustry
9500-51212	withi iene. then	mo	Elementary/Secondary (0-12) College (1-4or 5+)  10 Homemaker			Home	
	be filed within 72 hours after death w lal Hygiene. Ind other then "naturel", or Iteme 23a event, the Modical Examiter in ust	ø	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		
<u>a</u>	Mental Mental arked o	To B	Frank Baranowske		Grace	Carbaugh	
Maryland	should and Menistress market	_	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Stre	et and Number or Rura			c Code)
_	and 2 valth a		Robert P. Higdon, Sr./Husband 107 Oakton Ro	oad, Gaithe	ersburg, l	Maryland 2	.0877
Ore	ges 1 g		20a. Method of Disposition  1   20b. Place of Disposition (Name of cemetery, crematory or other parts). See the parts of Disposition (Name of cemetery, crematory or other parts). See the parts of Disposition (Name of cemetery, crematory or other parts). See the parts of Disposition (Name of cemetery, crematory or other parts). See the parts of Disposition (Name of cemetery, crematory or other parts). See the parts of Disposition (Name of cemetery, crematory or other parts). See the parts of Disposition (Name of cemetery, crematory or other parts). See the parts of Disposition (Name of cemetery, crematory or other parts). See the parts of Disposition (Name of cemetery, crematory or other parts). See the parts of Disposition (Name of cemetery, crematory or other parts). See the parts of Disposition (Name of cemetery, crematory or other parts). See the parts of Disposition (Name of cemetery). See the parts of Disposition (Name of cemetery). See the parts of Disposition (Name of cemetery). See the parts of Disposition (Name of cemetery). See the parts of Disposition (Name of cemetery). See the parts of Disposition (Name of cemetery). See the parts of Disposition (Name of cemetery). See the parts of Disposition (Name of cemetery). See the parts of Disposition (Name of cemetery). See the parts of Disposition (Name of cemetery). See the parts of Disposition (Name of cemeter). See the parts of Disposition (Name of cemeter). See the parts of Disposition (Name of cemeter). See the parts of Disposition (Name of cemeter). See the parts of Disposition (Name of cemeter). See the parts of Disposition (Name of cemeter). See the parts of Disposition (Name of cemeter). See the parts of Disposition (Name of cemeter). See the parts of Disposition (Name of cemeter). See the parts of Disposition (Name of cemeter). See the parts of Disposition (Name of cemeter). See the parts of Disposition (Name of cemeter). See the parts of Disposition (Name of cemeter). See the Disposition (Name of cemeter). See the Disposition (Name of cemeter).	place)	Date 200	c. Location - City or T	own, State
Ĕ	Pagent nent oury o		'4 □Donation 5 □Other (Specify) Parklawn Mem. Par	1	/2005 R	ockville,	Marvland
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke any injury or other treumatic		21. Signature of Funeral Gervice Licensees 22. Name and Add	dress of Facility DeV	Vol Funera	al Home	
Ц	20599			eer Park Di			D. 20877
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of d shock, or heart failure. List only one cause on each line.	lying, such as cardiac o	or respiratory arrest		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a Myocardial Infarction			7.	Onset and Death  1 Hour
	/Medical Examiner		Due to (or as a consequence of):				
		_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	ted	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or Injury				
	be executed ician and burial-transit	xan	that initiated events c.  resulting in death) Last Due to (or as a consequence of):				
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20	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat transit	o i	0.				
XO2	anding use	ician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	ery
	deatl	icia	in the past 12 months?  1 Yes 2 XNo  1 Live birth 2 Fetel death 3 Ectopic pregnant 4 Pregnant at time of death 5 Other (specify)	1cy		Month	Day Year
5	by the	Physi	9 ☐ Unknown 9 ☐ Unknown				
s,	requires that the	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
Records	equir sen si ould		Ascending Aortic Aneurysm		1 🗆 Yes	2X No 3 ☐ Prot	pably 4 □Unknown
ပ္	2 5 8	pie	Chronic Myelogenous Leukemia		24a. Was an autopsy	24b. Were auto	ppsy findings available mpletion of cause of
	Th ate pag	Completed	Rheumatoid Arthritis		performed 1 ☐ Yes 2 🔀	d? death?	
VII	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
0		2	Thinpatient 2 Ervoupatient 3 BOX			e 6 Other (Specif	y)
	ding I	ion	27. Manner of Death  1 X Natural 5 Pending (Month, Day Year) 28b. Time of Injury (Month, Day Year)  2 Accident investigation M		28d. Describe how i	injury occurred	
DIVISION	death death ctor: / the	licat	3 Suicide 6 Could not be	☐Yes 2☐No	28f Location (Stree	at and Number or Rura	Al Pauto Number
<u>}</u>	after Dire	ertification;	4 Homicide determined building, etc. (Specify)	•	City or Town, S	State)	a node Namber,
	spita nours nerel	O	29a. Certifier 1½ Certifying Physician: To the best of my knowledge, death occurred at the	time, date and place, (	and due to the caus	e(s) and manner as s	tated
	To the Hospital or Attending Phys within 24 hours after death.  To the Funerel Director: After this completely filled in by the funeral di	edical	(Check only one)  2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	opinion, death occurre	ed at the time, date	and place, and due to	the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier.	nse number	29d.	Date signed (Month,	Day, Year)
			> XVIA YWWW /VV\	03858	9	May 9, 20	005
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0000		11th / / 20	,
			Jonathan Plotsky, M.D., 15225 Shady Grove Ro	oad, # 102	, Rockvil	le, MD. 20	850
	Sta		31. Date filed (Month, Day, Year) MAY 0 9 2005  32. Pagistrar's Signature				
	Registr	ar	MINI V V LUUJ JOHNE JO POPOLO				

		= State Registrar		Ce	rtificate of D	eath		g. No.	1726
D1		1. Decedent's Name (First, Middle, La	st)				<ol><li>Date of Death Month</li></ol>	Day Year	3. Time 61-Déalt
Physici /Medic		Barbara E. Hecke	ett		Т		May 4,	T	9:02 a
Examin		4a. Facility Name (If not institution, giv	re street and number)		4b. City, Town, or L	ocation of Death		4c. County of Deat	in
		Montgomery Gener		1 (In yrs. last birthday)		ney If Under 24 Hrs.	8. Date of Birth	Montgor	nery hplace (State or Fore
Funeral		5. Social Security Number 6. 5	1 M 2 M F 7. Age	46 Yrs.	Months Days	Hours Min.	(Month, Day, Sept. 13	Year) Co	nnsylvania
Director	-	Usual Residence of Decedent						, 1500   101	y I vanile
Mo m		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Lin
동물	tor	Maryland Montgor	nery		Germantow	n			1 ☐ Yes 2x
1 28g	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
ene. than "natural", or liems 23a or 28a-f show the Muslical Examiner must be multiled at	aj D	13109 Millhaven	Place, Uni		20874			USA	
"natural", or Items 23a or 28a-f show	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Sp , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
분		1 Never Married 2 Married	1 Yes 2 N	0	1 ☐ Yes 2 No	Specify:		Specify: Wh	nite
ural',	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:	162 Doca	dent's Usual Occupat	ion		6b. Kind of Business/	Andustry
"nat	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Give	kind of work done du DO NOT use retired)	iring most of work	ing	CD. TWIC OF BUSINESS	moustry
than	mc	Elementary/Secondary (0-12)	College (1-4or 5-	+)	ffice Mana	ger		Medical	
Hygir ther tht, I		17. Father's Name (First, Middle, Las					e (First, Middle, N		
ental ced o	To Be	John Maylath				Elaine	Maxwe11		
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura any injury or other traumatic event, the Mulford once.	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Street at	nd Number or Rur	al Route Number,	City or Town, State, 2	Zip Code)
ultha 27 is rtrau		John D. Maylath/	Father	490	l Downland	Terrace	, Olney,	Mary1and	20832
Je ite Heg	3	20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other place	May		0c. Location - City or	Town, State
ento T. ₹		1 Burial 2 Cremation 3 ( 4 Donation 5 Other (Spec			aven Cemeter	,		ilver Spri	ing, Mary
ourtm outs		21. Signature of Funeral Service Lice	ensee Darli	2	2 Name and Address Francis J.	of Facility ins			
9 4 8 9	1	Anneway	re For /C	er	500 Univer	sity Blv	d, W, Si	lver Sprir	ng, MD 209
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ian and urial-transit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):					
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** May 10, 2005 Gerald Raymond 6:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cuppett-Weeks Nursing Home Oakland Garrett 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☑ M 2 ☐ F Director 214 03 4602 88 16, 1917 WV Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Madical Exemplest roughly at MD Garrett Kitzmiller 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 W. Main St 21538 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 spWhite 1 ☐ Yes 2 XNo δ If Yes, Give Year or Dates: WWII Specify: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Owner Deep Creek Oil Co. Fuel Distribution Pages 1 and 2 should be filed nent of Health and Mentat Hygis ant: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter Iman Agnes Mae Coleman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David A. Burdock PO Box 523 Kitzmiller, MD 21538 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages I Department of H Important: If ite any injury or ot 05/12/05 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Garrett Co. Mem. Gardens Oakland, MD 22. Name and Address of Facility David A. Burdock FH 21. Signature of Furberal Service License asyo 710 Church St. Kitzmiller, MD 23a. Part. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** a. atherosclerotic cardiovascular disease
Due to (or as a consequence of): /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed the attending physician and the for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, eq 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Alzheimers type dementia Completed peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? page 1 ☐ Yes 2 ☐ No 1 Yes 2 🔀 No or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes **3**€ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. М 1 Tes 2 No investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D30035 05-10-2005 (char 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donald R. Richter, M.D. 1533 Memorial Drive Oakland, MD 21550 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State 12 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 12:15P Edith Mae Jones May 7,2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Atlantic General Hospital Berlin Worcester If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2**X** F Director 88 MD 216-38-9844 Jan. 31, 1917 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. tnside City Limits 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Funeral Director MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11832 Assateague Rd. U.S. 21811 "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify Aq 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 should be filed w h and Mental Hygier 7 ie marked other tl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Addie Belle Adeline Timmons George Henry Bassett Rayne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Addie Belle Jones (daughter) 11832 Assateague Rd., Berlin, Md. 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State jo H **№** Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny injury or once. Sunset Memorial Park 5-10-2005 \* 4 □ Donation 5 □ Other (Specify) Berlin, Md. 21. Signature of Funes 22. Name and Address of Facility The Burbage Funeral Home Service Licenses 108 William St., Berlin, Md. 21811 23a. Part1. Entermi disease, of complications that saysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause or Immediate Cause (Final disease or condition Arrest-Myocardial Infarction **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner perTension Mmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. nding physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but percentage in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Obstructive tul monary 1 ☐ Yes 2 ☐ No 3 ☐ Probably # ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of centiler 29d. Date signed (Month, Day, Year) Teening Mis D56312 Berlin, MD 21811 Gregory W. STAMMAS, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tealthwan degistrar's Signature State Registrar

DHMH 17 Rev 1/2001

ESIX

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year JOHNSON 2005 MAY 4 3:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Landover 7717 Normandy Road Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🕱 F Director Yrs 579-02-7275 42 March 28 1963 Maryland Usual Residence of Decedent with the Maryland t0a, State 10c. City, Town or Location 10b. County ral, or items 23a or 28e-f ahow Examiner must be notified at 10d. Inside City Limits Director 1X Yes 2 No MD Prince George's Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death 7717 Normandy Road 20785 U.S.A. by Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Tr Never Married 2 ☐ Married 1 ☐ Yes 2 😾 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced "netural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) other than College (1-4or 5+) 12th Financial Mgmt. Specialist Government 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked oth any lipiry or other treumatic event page. 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Proctor 2 Melwood S. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Plowden/Daughter 7717 Normandy Rd. Landover, Maryland 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 😾 Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) May 12,2005 Landover, Maryland Harmony Cemetery 21. Signature vice Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the use 15e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Small Bowel Adenocarcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or hour) that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 I No 24a. Was an autopsy performed? 1[**X**Yes 2 🗆 No or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 AResidence 6 Other (Specify) P 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number, City or Town, State) ģ 4 | Homicide within 24 hours a To the Funerel D 1 Cartifying Prysician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Bla Cathler cai (Check only

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) State Registrar

MAY 1 0 2005

30. Name and address of Jerson who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Stephen Staal M.D. 1221 Mercantile Lane 3rd Floor, Largo, Maryland 20744

29c. License number

D18219

29d, Date signed (Month, Day, Year)

May 6, 2005

		1	State of Maryland / Dep	eartment of Health and Mertificate of Death	lental Hygier Reg.	6000	17268
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Elbert C. Johns			005	8:23pm M
}	Examin		a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Ft. Washington Hospital	Ft. Washington		Prince Geo	
	Funeral		5. Social Security Number 6. Sex $146-46-4164$ 16. Sex $145$ M $2\Box$ F 7. Age (In yrs. last birthday Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye) Jan. 20,	1948 Mar	place (State or Foreign ntry) Cyland
	Director		Usual Residence of Decedent		Jan. 20,	1940 Hai	yranu
	yland		10a. State 10b. County 10c. City, Town or t				10d. Inside City Limits
	a-fsl	ctor	Maryland Prince George's Upper Ma	rlboro			1X□Yes 2□No
	or 28	Director	10e. Street and Number	10f. Zip Code		Citizen of What Cou	
	ath w	rai	4715 Cashill Court	20772		nited Stat	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Mardical Examinar mantice notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	etc.
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Maryland	uld be fil Aental H rkad oth tic evan	To Be	17. Father's Name (First, Middle, Last) Russell Barnes	Alice J	e (First, Middle, Maid ohns	gen Surmame)	
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100	in of the		1 ▼Burial 2 ☐ Cremation 3 ☐ Removal from State	ematory or other place)			
Baltimore,	it. Pa intmer intant injury	1				linton, Ma	iryland
Ba	Depariming Department of the partment of the p		Joanna E. Claberry	22. Name and Address of Facility McGuire Funeral Se 7400 Georgia Ave.	N.W. Wash		
			23a. Part Enter the disease, or comblications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	MIDERY MISE	136		
	/Medical Examiner		Due to (or as a consequence of):	MALINS			
	0.56	e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	1110101105			
	uted d ansit	Examine	cause, Enter Underlying Cause (Disease or injury that initiated events  c			1	1.0
o,	icate be executed physician and s the burial transit		resulting in death) Last Due to (or as a consequence of):				
8760,	ate be nysicia he bu	Ical	d				
9	e as t	Med	IF FEMALE:				
Box	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliv Month	very Day Year
o.	B ₹ #	ysic	1 Yes 2 No 9 Unknown	Cities (specify)			
Д.	res that the igned by be detact	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
rds	quires n sign				1 🗆 Yes	2 No 3 Pro	bably 4 □Unknown
Division of Vital Records,	law requires that as been signed b 2 should be deta	Completed	1		24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
ä	9 4 9	mo			performed	d? death?	2 No
Ita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		h (Check only one)	1	210
Ž	S S =	ို	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati			e 6 Other (Speci	ify)
ou o	de la eur	ertification;	27. Many of Death  1 Natural 5 Pending (Month, Day Year)  28a. Date of Injury (Month, Day Year)		28d. Describe how i	injury occurred	
isic	Attending r death. ector; Afte by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury - At home farm :		28f. Location (Stree	at and Number or Rur	ral Route Number,
Dί<	after Direction by	ertif	3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Could not be determined  6 ☐ Could not be determined  6 ☐ Could not be determined  6 ☐ Could not be determined  6 ☐ Could not be determined  6 ☐ Could not be determined	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town, S	State)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Completely filled in by the fu	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.				
	To the Within To the	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
	5		> 1 Vamead 111	1914220		5-40	2005
			30. Name and address of person who completed cause of death (Item 23a) (Typ  Ne   A. Meade 9811 M.	e. Print) allard Dr La	vrel Y	1/207	08
	Sta Regist		31. Date filed (Month, Day, Year) MAY 0 6 2005 32. Redistrar's Signature	garle.			

			1 - For Stata Registrar	State of Marylar	nd / Depa		ealth and M	Mental Hyg	•	05	Production of the last of the	269
	Discosia:		1. Decedent's Name (First, Middle, Last)	)				2. Date of Deat Month	h Day	Year	3. Time o	of Death
	Physici /Medio		Carol Cha	alkley	i.	Johnson		May 1,		, 50.	3:22	ам
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	l .	4c. County	of Death		
			Genesis Woodside	Center		Silver	Spring		Mon	tgom	ery	
	Funeral Director		5. Social Security Number  578-60-2278  Usual Residence of Decedent	7. Age (In yrs. 60	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 8,	Year)		place (State ntry) homa	or Foreign
	land		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation					10d. Inside C	City Limits
	Mary f sh	ō	Maryland M	lontgomery	S	ilver Spr	ring			+	1 🗌 Yes	\$ <b>3√3</b> √No
	the 28a	ect	10e. Street and Number			10f. Zip Code		1	Og. Citizen of W	hat Cou	ntrv?	
	Mith Be or	⊡	8724 Cameron Stre	eet. #327		20910			USA			
	leath ns 2;	era		12. Was Decedent Ever in U	l.S. 13.	Was Decedent of Hi	Ispanic Origin? (Sc	pecify Yes or No-		- Ameri	can Indian,	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene. d other then "natural", or Items 23a or 28a-f show event, it e Medical Eracili at must be routified an	by Funeral Director	1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Armed Forces?  1  Yes 2 XNo If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1□Yes 2ॲNo		o Rican, etc.)	Specify:	k, White, Whi		
Ö	2 ho	Completed	15. Decedent's Edu		16a. Dece	dent's Usual Occupa	ation		16b. Kind of Bu	siness/In	dustry	
215	7 olo 7. Media	ple	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give	kind of work done o DO NOT use retired	during most of world ()	king				
21	d with	E	Lionomary/Secondary (6-12)	4	A:	rchiver			Governmen	nt Con	ntracto	r
B	e file it Hyg othe	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, I	Maiden Sumam	e)		
<u>a</u>	itd be lenta ked ic ev	To B	Donald Thomas Cha	alkley			Louise	e Steven	son			
ary	12 should be filed within h and Mental Hygiene. 7 Is marked other then "traumatic event, the Me.		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailin	ng Address (Street a	and Number or Ru	ral Route Number	City or Town,	State, Zip	Code)	
Ž	nd 2 alth a 27 Is		Oswald C. Johnson	n/ Son	2962	Pintail	Place, U	nit E, Wa	aldorf,	MD	20603	
Baltimore,	permit. Pages I and 2 should be Department of Health and Menta Importent: If Item 27 Is marked eny Injury or other traumatic evonce.		20a. Method of Disposition		Place of Dispo	sition (Name of matory or other plac	a)   ne		20c. Location -	City or To	own, State	
Ę	Page ent o nt: If		1 ☐ Burial 2 🖫 Cremation 3 ☐ F  `4 ☐ Donation 5 ☐ Other (Specify)	temoval from State		an Crematory	1 Liuy		Alouand.	. i a	77:	nia
≣	artm orter Inju		21. Signature of Funeral Service Licens		- 62	Name and Aderes			Alexand:		VIL	IIITa
B	Dep Imp eny		Varian (	il les	5	00 Univer	sity Blv	d, W, Si	lver Sp	ring	,MD 20	0901
	Pnysician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	ications that caused the deal ne cause on each line.  Lung Neop  a.  Due to (or as a consec	lasm	er the mode of dying	g, such as cardiac	or respiratory arre	est,		Approxima Interval Be Onset and Months	tween Death
	Examiner			Due to (or as a corrsec	(uerice or).							
	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):							
,097	te be executed ysiclan and se burial-transit	cal Exa	resulting in death) Last	Due to (or as a consec	quence of):				-			
P.O. Box 68	The law requires that the death certificate be executed ate been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of c	al death 3	Ectopic pregnancy Other (specify)			23d. Date Mor		-	Year
	uires that signed t	by	Part II. Other significant conditions con	ntributing to death but not res	sulting in the u	nderlying cause give	en in Part I.		oacco use contr es 2 □ No		he cause of pably 4 🗔	
Records,	The law require rate has been sip page 2 should b	Completed						24a. Was a autops perform	y p ned? d	rior to co eath?	ppsy findings mpletion of	available cause of
a		e C	25. Was case referred to medical				26 Place of Doo	th (Check only on		☐ Yes	2□ No	
Vital	Physician: this certificatal director, p	O B	evaminer?	fospital: 1 ☐ Inpatient 2 ☐	ED/Outpation	Othe	200	ome 5 Reside		s /Cassil		
of	ding Pr		27. Manner of Death  1 Natural  2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injury Work	/ at	28d. Describe ho			у)	
Division	= 5 to to	Certifications	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, sti	eet, factory, office		28f. Location (St City or Town	reet and Numbe n, State)	er or Rura	al Route Nur	mber,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	ledical (	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kno nar: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the tim vestigation, in my op	ne, date and place, pinion, death occur	, and due to the carred at the time, da	ause(s) and mai ate and place, a	nner as s	tated. the cause(	(s)
	To the To the Comp	×	29b. Signature and title of certifier			29c. License	e number	2	9d. Date signed	(Month,	Day, Year)	
	1		1 Mm	Mp		D32	332		May 2	, 20	05	
	/		30. Name and address of person who co Suresh K. Gupta			Print) a Avenue,	#220, S	ilver Sp	ring, M	D 20	902	
<b>.</b>	Sta Regist		31. Date filed (Month, Day, Year) MAY 0 6 208	3 Registrar's Sign	ature dos	de						

			For 1_ State	State of Marylan	d / Depa	artment of H	leaith and	Mental Hyg	iene	DIG.	17070	
			State Registrar	<del> </del>	Cei	tificate of I	Death		eg. Nor 💛 🖔	ل ا	1/2/0	
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Deat Month	Day	Year	3. Time of Death	
	/Medic	al	WALTER	A. JOHNS	ON				28, 2		9:15 A <sup>M</sup>	
	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town, or		atn	4c. County			
			307 Frederick 5. Social Security Number 6. Sex		last hirthday)	If Under 1 Year	Ville   If Under 24 Hi	rs. 8 Date of Birth		NTGO		
	Funeral Director			kM 2□F 93	Yrs.	Months Days	Hours Mi		Year)	Coun	lace (State or Foreign stry) Sh. DC	
			Usual Residence of Decedent					Gary 15	,		<u> </u>	_
	how		10a. State 10b. County		y, Town or Lo					10	0d. Inside City Limits	
	B Ma	cto	MD Montgo	omery	ROC	kville					1⊠Yes 2 □ No	
	or 28	Director	10e. Street and Number			10f. Zip Code		11	0g. Citizen of \		try?	
	23a		307 Frederick				0850			S.A.		_
	tems	Funeral	11. Wantai Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin? ( an, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)		ce - America ck, White, e		
36	s afte	by F	1 ☐ Never Married 2 ☐ Married  3 ※ Widowed 4 ☐ Divorced	1 ☐ Yes 2 <b>X</b> No If Yes, Give Year or Dates:		1□ Yes 2√□ No	Specify:		Specif	y: Bla	ack	
21215-0036	be tiled within 72 hours atter death with the Maryland tal Hyglene. d other than "natural", or tlems 23a or 28a-f show event, tre Madical Exertiner sast be tredified at	be to	15. Decedent's Educ		16a, Deced	ient's Usual Occup	ation		16b. Kind of B	usiness/Inc	dustry	
 5	in 72	olet	(Specify only highest grade	e completed)	(Give	kind of work done of OO NOT use retired	during most of w	rorking	102. 11	00111000011110	ido.i.y	
212	i with	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Custodi	an		Montg	omer	y County	
	il Hygi other	BeC	17. Father's Name (First, Middle, Last)					ame (First, Middle, A		ne)		
<u>la</u>	uld by Aenta rked rice	To E	Thomas Johns	son				artha Ja				
Maryland	s 1 and 2 should be tiled within 72 hours atter death with the Marylan I Health and Mental Hyglene. item 27 is marked other than "netural", or items 23a or 28a-f show other treumatic event, tre M. Alcal Exa. ili er . ast Le riciffied at		19a. Informant's Name/Relationship (Ty)		19b. Mailir	g Address (Street	and Number or I	Rural Route Number,	City or Town,	State, Zip	Code) 20904	
	of Health item 27		Jean D. Frazie		-			rk Dr.,				
ore	of H		20a. Method of Disposition	emoval from State		sition (Name of natory or other place			20c. Location -			
Ē	Pages ment of it		`4 □ Donation 5 □ Other (Specify)	/ Li		Park C			Rockv			
Baltimore,	permit. Pages Department of Importent: If it any njury or o		21. Signature of Funeral Service License	Anala	1.4/ 0			NOWDEN F			•	
	707 a a		501 M4 /	LICONS				t., Rock		, MD		
Ш			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	cations that caused the deat ne cause on each line.	n. Do not ent	er the mode of dyin	ig, such as cardi	ac or respiratory arre	est,		Approximate Interval Between Onset and Death	
	Physician	ñ	Immediate Cause Inal disease or condition resulting in death)	CHH						- 1	3 30-05	5
H	/Medical Examiner		Tooling in dodain,	Due to (or as a conser	uence of):	0					Vanne	
		li li	Sequentially list conditions,	Due to (or as a conseq	uence of):	υ	1 1			-	76015	-
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Entire of denying Cause (Disease or injury that initiated events	Falat	age	hond	1 dis	ease		12	3-20-05	
,	execu n and ial-tra	Exa	resulting in death) Last	Due to (or as a conseq		100.190	. 0//	<u>Cace</u>	-		1	_
760,	icate be executed physician and s the burial-transit	call		1							lears	
89												_
Вох	h cer endin	N N	230. was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy	,			te of deliver	•	
m m	deat	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of d		Other (specify)			Mo	onth	Day Year	
P. O.	that the death certitica ed by the attending ph detached for use as th	Physician/Med	9 Unknown					T as Birry				
	as du	by	Part II. Other significent conditions con	ntributing to death but not res	ulting in the u	nderlying cause give	en in Part I.		V		e cause of death? ably 4 □Unknown	
Records,	w requir been si should I	Completed						1  Ye	s 2 No	3   1000	ably 4 Golikilowii	
ec	ne law has b ge 2 st	nple						24a. Was ar autops	y	prior to con	psy findings available apletion of cause of	
	19 -	Cor						perform 1 Tes 2		death?	2 🗆 No	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		oth	or	eath (Check only on				-
of	Phys this ral dii	<u>1</u>	1 Yes 2 No	1 Inpatient 2 2	ER/Outpatien	I 3L DOA	4 🗆 Nursing	Home 5 seside 28d. Describe ho			)	-
on	ding h. h. Atter funer	tion	1 Natural 5 Pending	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No	256. 256025	,,			
Division	or Attending after death. Director: Atter in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he	ome, farm, str	eet, factory, office		28f. Location (Str		er or Rural	l Route Number,	
Š	after after Dire	Certification:	4  Homicide	building, etc. (Specif	(y)			City or Town	, State)			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Phys	sician: To the best of my kno	wledge, death	occurred at the tin	ne, date and pla	ce, and due to the ca	use(s) and ma	anner as sta	ated.	
	n 24 he Fu	edical	(Check only 2 Medical Exemination one)	ner: On the basis of examina and manner stated.	ition and/or in	vestigation, in my o	pinion, death oc	curred at the time, da	ate and place,	and due to	the cause(s)	
	To the Hospital within 24 hours a To the Funerel Completely filled	Ž	29b. Signature and title of certifier	7 11.H.O	115	29c. Licens	e number	29	d. Date signe	d (Month, E	Day, Year)	
•	_		Shama 1	1. Mula	IND	100	16138	2	0/5	105	2+1-	
	10		30. Name and address of person who of	empleted cause of death (yer	23a) (Type,	Print) 1481	6 PAY	SICIANS	> LAN	JE, U	une 15 2	-
			SHAMA R.M	22. Registrar's Signa	1).	KOC	KV1L	LE, MI	20	1850	)	
	Sta Registi		31. Date filed (Month, Day, Year)	And Andreas Signa	100 A	le le						

		State of Maryland / Depa  For State Registrar  State of Maryland / Depa		lental Hy	-
Physici /Medio	al	Decedent's Name (First, Middle, Last)  ALICE CATHERINE JENKINS      4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	2. Date of Dea Month May	2005 3. Time of Death  3. Time of Death  3. Time of Death
Examir Funeral Director	ler	7024 Elmo Dryden Road  5. Social Security Number 6. Sex 1 M 2 XF 7. Age (In yrs. last birthday)  018-24-0019 75 Yrs.	Westover If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, Da Nov • 25	Somerset  b. Year)  7. 1929  Somerset  9. Birthplace (State or Foreign Country)  Massachusetts
Violet of the Maryland out be filed within the Maryland out be filed within 72 hours after death with the Maryland Mental Hygiene.  Arked other than "neturel", or items 23a or 28a-f show etic event, the Medical Evert in art must be notified at	Funeral Director		10f. Zip Code  21871  Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto		10d. Inside City Limits  1 ☐ Yes 2 ☑No  10g. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.
filed within 72 hours after than "neturel", or int, the Ne dical Eratur	Completed by	3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give I			Specify: White  16b. Kind of Business/Industry  Federal Government  Maiden Sumame)
sh and man	To Be	Phillip Patrick Murphy  19a. Informant's Name/Relationship (Type, Print)  Charles M. Jenkins (husband)  7024	Alice Ge g Address (Street and Number or Rur Elmo Dryden Rd.	rtrude al Route Numbe	Welch er, City or Town, State, Zip Code) r, MD 21871
parmit. Pages 1 and 2 Department of Health a Importent: if item 27 is eny injury or other tre once.		21. Signature of Fureral Service Licensee 22.		/2005 eral Ho	Salisbury, Maryland  me, P.A. City, MD 21851
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	er the mode of dying, such as cardiac Creut Fel dt	or respiratory and	rest, Approximate Interval Between
ficate be executed physician and streets the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
the death certification of the attending of the attending of the attending of the attending of the asset of the asset of the asset of the attending of the atte	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
VICAL INECCIOUS, P.O. DOX 001000, sicien: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Completed by Pl	Part II. Other significant conditions contributing to death but not resulting in the un Bilatiral DVT Chronic A fils	nderlying cause given in Part I.	1 24a. Was autor	
on or vital ling Physicien: n. After this certifica funeral director, I	To Be	25. Was case referred to medical examiner?  1  Yes 2 No		ome 5 Residence	dence 6 Other (Specify) now injury occurred
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical Certification;	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, streeth building, etc. (Specify)  29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or inv	occurred at the time, date and place,	City or To	cause(s) and manner as stated.
To the within 2 To the I complet	Med	29b. Signature and title of exercises  20 Name and address of extrem who completed cause of death (Item 23a) (Types	29c. License number  DUD 506 (19) Print) 1205 Perham	4	29d. Date signed (Month. Day, Year)
St Regist	ate trar	30. Name and address of person who completed cause of death (Item 23a) (Type,  State filled (Month, Day, Year)  31. Date filled (Month, Day, Year)  32. Desistrar's Signature	105 Perhan	Dr Sun	it 14 Schisbury M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 6 per ffi 8845 /-21-05 vt
State of Maryland? Department of Health and Mental Hygiene () () 5

1 - State Registres Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 22/0 M 04 2005 MAY William E. Johnson, Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner TRIBOT EASTON HOSPITAL MEMORIAI If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Hours Months Days Director May 11,1921 Maryland 83 220-01-3209 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show 1 ☐ Yes 2 No Examiner must be notified Director Maryland Kent Worton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21678 11174 Boyer USA Ln Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 ⊉Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify à 3 XWidowed 4 □ Divorced Black "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry treumetic event, the Mcdical 15. Decedent's Education (Specify only highest grade completed) d 2 should be filad within 7, ih and Mental Hygiene. 7 Is markad othar than "ne College (1-4or 5+) Elementary/Secondary (0-12) Charles Cassey & Son 6 Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Susie Tiller Thomas Johnson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Department of Health a Important: If itam 27 is any injury or othar tre once. P.O.Box 80, Galena, Maryland 21635 Carlson Johnson / Son 20b. Place of Disposition (Name of N. C. C.) L. Fountain Site (Big Woods) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 05-11-2005 Chestertown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21 Thomas of Funeral Service License Bennie Smith Funeral Home Road #298, Chestertown, Maryland 21620 160 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG CANCER **Physician** /Medical Due to (or as a consequence of) **Examiner** ARDIOMYOPATHY social tielly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner Physician: The law requires that the death certificate ba exacuted the burial-tran Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Cther (specify) P.O. | 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 3 No 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 ■Natural 28a. Date of Injury (Month, Day Year) Certification; To the Hospital or Attanding After 5 Pending 1 Tes 2 No death. investigation 2 Accident Diractor: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 24 within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 15 Mufrotses 12005 50059487 30. Name and Address of person who completed cause of death (Item 23a) (Type, Print) Botsis M.D. 219 5.... Registrar's Signature 219 S. Washington Street, Easton, Maryland 21601 John 31. Date filed (MAY a1 YO') 2805 State Registrar

JOHNSON

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day 10:20 P. **Physician** 30, Nancy Croker Jarvis 2005 April /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 77 December 15,1927 Washington, Director 578-34-7152 Usual Residence of Decedent iiii. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ritment of Health and Mental Hygiene.
Critant: If item 27 is marked other than "natural", or Items 23e or 28e-1 show miny or other traumatic event, the Medical Event activate the multibud at the contract of the contract 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Gaithersburg Maryland Montgomery 1 1 Yes 2 □ No Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20886 United States 19301 WATKINS Mill Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify: 3 ☐ Widowed 4 € Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medical Abstractor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Buryl Smith Croker Charles ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S 8813 Watts Mine Terrace, Potomac, MD 19a. Informant's Name/Relationship (Type, Print) James E. Croker/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place)
Geo. Wash. University
Medical Center 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State May 2,2005 Washington, D.C. 4 Donation 5 ☐ Other (Specify) permit.
Departn
Imports
any inju 22. Name and Address of Facility Columbia Mortuary Services, Inc. 21. Signature of Funeral Service Licensee P.O. Box 58007 Washington, D.C. 20037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on providing inc. Approximate Interval Between Onset and Deat Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to for as a construence **Examiner** Sequentially list conditions, any, leading to in redial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be exacuted burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown څ 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes SZ No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 Pending 1 Tes 2 No To the Hospital or Attandii within 24 hours after death. To tha Funaral Diractor: A 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tive of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Dr William Dooley, M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 9 2005 Registrar

			1 - For Amend Item 2	State of 4a,26 p	Maryland / er Verb.	Depa <b>C</b>	artment of H 362423/9	ealth and	d Mental Hyg	giene Reg. No.	005	17071
	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of Dea	ath Day	Year	3. Time of Death
	/Media			FRANCIS					May	12	2005	8:15 a.M
	Examin	er	4a. Facility Name (If not institution, give		ber)		4b. City, Town, or Myersv		ath		unty of Death ederic	k
	Funeral		12736 Loy Wolf R 5. Social Security Number 6. Sex		. Age (In yrs. last bi	irthday)	Myersv If Under 1 Year	If Under 24 h	Irs. 8. Date of Birt in. (Month, Da			Nace (State or Foreign
	Director		217-16-2258	M 2□F	84	Yrs.	Months Days	Hours M	Feb. 6,	1921	Cour	yland
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	m or Lo	anting				Т.	0d. Inside City Limits
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	72 hours after death with the Maryland neturel', or items 23s or 28e-f show disul Exacilian musi be indiffied at	Funeral Director	11. Marital Status	12. Was Deced	lent Ever in U.S.	13.	Was Decedent of His f Yes, specify Cubar	panic Origin?	(Specify Yes or No-		Race - Americ	
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yla	Meni Marke Marke	<sup>2</sup>	Equilla Kline						Ruth Wol			
Maryland	d 2 sh th and 7 Is m treum		19a. Informant's Name/Relationship (Ty) Gerald F. Kline,						Rural Route Numbe , Winchest			
6	1 and Healt tem 2 other		20a. Method of Disposition	111/610	20b. Place of	of Dispo	sition (Name of		Date		on - City or To	
Ω	ages ant of it: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donatiop 5 ☐ Other (Specify)	emoval from St	St. Pa	aul'	natory`or other place s Luthera		14, 05			Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23a or 28e-f show with injury or other treumatic event, the Mudical Exercit et must be rediffed at pDGs.		21. Signature of Funeral Service Ligense	6)		22	. Name and Address		-		n Stre	-
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	/Medical Examiner		resulting in death)	Due to (or	r as a consequence	o():	(1)					
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	To the Hospitel or Attending Physicien: The law requires that the death certif within 24 hours atted death.  To the Funeral Directors After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one)  Certifying Phys 2 Medical Examin	ician: To the beer: On the bas and manne	is of examination ar	e, death nd/or inv	occurred at the time estigation, in my opi	, date and pla nion, death oc	ce, and due to the c curred at the time, d	ause(s) and ate and plac	manner as st e, and due to	ated. the cause(s)
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	State of Maryland / Dep 1- StateAmend Item 1&Unpend Item 23a, 27e	28a-f per me G843 5-26	-05 tas2 0 0 5   72 7 1
Physician	Decedent's Name (First, Middle, Last)  Audrey Ann Keels- Briscoe	2. Date Mor MAY	
/Medical Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Funeral	FORT WASHINGTON HOSPITAL  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	FORT WASHINGTON  If Under 1 Year   If Under 24 Hrs.   8. Date	PRINCE GEORGES  9 Birthplace (State or Foreign
Director	250-86-7791 1□ M 2反F 55 Yrs. Usual Residence of Decedent	Months Days Hours Min. (Mon. May	e of Birth noth, Day, Year) 20, 1949 Seight Manning, S.C.
show	10a. State 10b. County 10c. City, Town or L	ocation Shington	10d. Inside City Limit: 1√∑ Yes 2 ∑ No
death with the Maryland ms 23s or 28s-f show fraust be notified at	Maryland Prince Georges Ft. Was	10f. Zip Code	10g. Citizen of What Country?
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12 should be filled within of and Mental Hyglene. 7 is marked other than "recumatic event, it a Mac	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rural Route Dillon Court	Number, City or Town, State, Zip Code)
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The law require cate has been six page 2 should be Completed	•		a. Was an autopsy prior for completion of cause of performed?  Yes 2 \( \subseteq \) No
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the Hospi in 24 hou tha Funer pletely fill	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, dea (Check only one) 1 ☐ Certifying Physician: To the basis of examination and/or i and manner stated.	ith occurred at the time, date and place, and due nvestigation, in my opinion, death occurred at the	e time, date and place, and due to the cause(s)
To the within to the comple	29b. Signature and title of certifier	29c. License number OCME	29d. Date signed (Month, Day, Year)
-6	30. Name and address of person who completed cause of death (Item 23a) (Type	o. Print) 111 Penn Street	MAY 15, 2005 Baltimore, Maryland 2120
State Registrar	31. Date filed (Month, Day, Year) 37 Registrar's Signature	edi)	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 8 **Physician** MAY Month 2005 3:00PM M VIRGINIA M. KELLEY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** WILLIAM HILL MANOR TALBOT EASTON If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) SEPT 22 19 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F 87 217-09-0678 Director MARYLAND 1917 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location show 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f shor other traumatic event, the Medical Exprehenmest be notified at MD TALBOT EASTON 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 DUTCHMANS LANE 21601 USA death v Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ If Yes, Give Year or Dates: Specify: Specify: 3 X Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 12 HOMEMAKER permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 900g. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GUS MIELKE BONNIE BECKNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 180 CHESTNUT VALE FARM RD, CENTREVILLE, MD 21617 PATRICIA M. RHODES/NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) SPRING HILL CEMETERY 5-13-2005 EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 MERCERON 2 MOHN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** rdio resulting in death) /Medical Due to (or as a consequence of): Examiner 1100 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and the for use as the burial-transit the death certificate be executed Tasce Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy detached for Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ page 2 should be 1 Tes 2 X No 3 Probably 4 Unknown Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed Kentater Me 1 🗌 Yes 2 0 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28 No 1 ☐ Yes 2 ER/Outpatient 3□ DOA 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Naturel 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident al or Attence after death Director: 6 Could not be determined 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Miam HWOOZ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501 DUTCHMANS LANE EASTON, MD 21601 WILLIAM H. WOOD, JR. M.D. 31. Date filed (Month, Day, Year) 3 Registrar's Signature State Registrar

		1 - For State Registrar	State of Ma		d / Depa	artme	nt of H			•	6007	17277
Physici		1. Decedent's Name (First, Middle, I	_ast)						Mo		Day Ye	
/Medic Examin		Max Kleiner  4a. Facility Name (If not institution, g	ive street and number)			4b. City	, Town, or	Location of De	Ma:	У	3 200 4c. County of D	
LAGITIII	iÇi	Suburban Hospita			į		hesd				Montgo	
Funeral		Social Security Number 6		e (In yrs. la	st birthday)	If Und	r 1 Year Days	If Under 24 H	Hrs. 8. Dat	e of Birth onth, Day, Ye		Birthplace (State or Foreign Country)
Director		Usuel Residence of Decedent	141W 2 1	90	Yrs.	3300				23/19		Poland
darylar f show	ō	10a. State 10b. County  MD Montgon			Town or Lo							10d. Inside City Limits 1 ☑ Yes 2 ☐ No
7 28e-	Funeral Director	MD Montgon  10e. Street and Number	lery	KOC.	kville		p Code			10g.	Citizen of What	Country?
h with	al Di	1799 East Jeffer	son Street	Apt-	214	20	852			Un	ited St	ates
ems (	ner	11. Marital Status	12. Was Decedent 8 Armed Forces?			Vas Deci	edent of H	ispanic Origin? In, Mexican, Pu	(Specify Ye		14. Race - A	merican Indian, /hite, etc.
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d with	mo	Elementary/Secondary (0-12)	College (1-4or 5	+)	Self-	Emp1	oved			R	eal Esta	ate
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ould be file Mental Hy larkad oth	To	Israel Kleiner						Pelsa	Salzbe	erg		
permit. Pages 1 and 2 should be Department of Health and Menta important: if Item 27 is marked eny injury or other traumatic evonce.		19a. Informant's Name/Relationship Regina Kleiner -									ty or Town, State	e, Zip Code) 20852 <b>cville,</b> MD
nt of Her if item		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3	☐Removal from State	l	metery, cren	sition (Na natory or	me of other plac	e)	Date	200	. Location - City	or Town, State
artmerartmery		<ul> <li>4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice</li> </ul>		Meno	orah G			ss of Facility	/05/20	005 Ro	ckville	MD
permi Depa impo any ir		) ala 1	Down	0	H	ines	-Rina	aldi Fu	neral	Home,	Inc	ing,MD 20904
Physician /Medical Examiner	er	23a. Part1. Enter the disease, or of shock, or heart failure. List on immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Con est  Due to (or as:  b. Ischemi  Due to (or as:	ive ( a consequ c Hea	Cardio ence of): art Di	myop	athy	g, such as card	diac or respir	atory arrest,		Approximate Interval Between Onset and Death
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w requires that the death certifics been signed by the attending pt should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3 🗆	Ectopic (	pecify)				23d. Date of Month	delive <b>ry</b> Day Year
iaw requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions	contributing to death bu	ut not resul	iting in the ur	ndertying	cause give	en in Part I.	23			to the cause of death?  Probably 4 □Unknown
The far ate has page 2	Completed								-	a. Was an autopsy performed [Yes 2X]	? prior death	
ician sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:				Othe	26. Place of D				
the state of	- To	1 ☐ Yes 2 🗶 No 27. Manner of Death	1 N Inpatre		R/Outpatient 28b. Time of			4 🗆 14012111			6 Other (S	pecify)
ding F h. After funera	tlon	1 XNatural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	Injury	М	28c. Injury Work	(? Yes 2 ☐ No	200. De	SCIDE NOW II	ijury occurred	
or Attending siter death. Director: After in by the fune	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 00 01 (1:	iry - At hon (Specify)	ne, farm, stre					ation (Street or Town, St		Rural Route Number,
To the Hospital or Attendin, within 24 hours effer death.  To the Funeral Director: Att completely filled in by the fun	edical Ce	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of aminer: On the basis of	examinati	rledge, death on and/or inv	occurre	at the tim	ne, date and pla pinion, death or	ace, and due	to the cause e time, date	e(s) and manner and place, and c	as stated. lue to the cause(s)
o the ithin ( o the smple	Med	29b. Signature and title of certifier	and manner sta	ted.			c. License				Date signed (Mo	
⊢ 3 F 8		> Alparely	mour	7 1	YID.		-276			1	/04/200	
12		30. Name and ad ress of pers in				Print)					, 0 1/200.	
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	e Physici	an	Decedent's Name (First, Middle, Las     Susan M. Kol	•					2. Date of I Month May			3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give		mber)		4b. City, Tow	m, or Location of			c. County of Death	
			Gilchrist Cente 5. Social Security Number 6. So		7 Ann (In w	s. last birthda	Tows		24 Hrs. 8. Date of I		ontgomer	
	Funeral Director			_M 2€F	6		Months Da	ays Hours	Min. (Month,	Birth Day, Year 19		place (State or Foreign intry)  ington, D.C
-	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. (	City, Town or	Location					10d. Inside City Limits
:	e Mary ta-fsh	ctor	Maryland Howard		(	Columb	ia					1 ☐ Yes 2∕☐ No
: :	h with th	al Dire	10e. Street and Number 7436 Sandalfoot W	ay			10f. Zip Coo 210			10g. C	itizen of What Cou	•
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department: If time 27 Is marked other than "natural", or items 23a or 28a-f show any injury of other traumatic event. If a Marical Examiner must be muithed at once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Dece Armed Fo 1 Tes If Yes, Giv Year or D	rces? 2 No /e X	U.S. 1	3. Was Decedent If Yes, specify (	Cuban, Mexican,	in? (Specify Yes or I Puerto Rican, etc.)	No-	14. Race - Ameri Black, White, Specify: W	
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Baltimore, Maryland 21215-0036	withIn iene. than	Completed	Elementary/Secondary (0-12)	College (1 2 Yea	I-4or 5+)		ive kind of work do e. DO NOT use re nistrati			Fed	eral Gov	ernment
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Ma	nd 2 salth an 27 ls i		Ronald L. Kolb -		i				r or Rural Route Num , Columbia			p Code) 21046
ore,	of Hei		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 🖾		20b	. Place of Dis	sposition (Name o	f	Date	-	ocation - City or To	
Ħ i	uit. Pagartment		<ul><li>4 □ Donation 5 □ Other (Specify</li><li>21. Signature of Funeral Service Licen</li></ul>	)	K			1	5/9/2005			h, Virginia
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5-3 ords, P	quires tha in signed I uld be det	by	Part II. Other significant conditions of	ontributing to de	eath but not ri	esulting in the	e underlying cause	given in Part I.			į	the cause of death?
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υβ of Vital	d is	To Be	10 163 22 140	Hospital: 1 ☐ I	npatient 2	□ ER/Outpat	HOIL DON	Other: 4 Nur	of Death <i>(Check only</i> sing Home 5 ☐ Re		Other (Specif	m hospico
3 6	ding , . After fune	atlon:	27. Manner of Death   Natural 5 Pending investigation		of Injury th, Day Year)	28b. Time Injun		njury at Work? 1 □ Yes 2 □ N	28d. Describe	ujni wođe	ry scaurred	1.4
4 5	in the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place buildi			street, factory, off		City or T	own, State	,	
2/8	To the Hospital within 24 hours a To the Funeral C completely filled	Medical	29a. Certifier (Check only one)  Certifying Physical Example (Check only one)	mer: On the ba	best of my kasis of examiner stated.	nowledge, de nation and/or	eath occurred at the investigation, in n	e time, date and ny opinion, death	place, and due to the occurred at the time	e cause(s e, date an	) and manner as s d place, and due to	tated. o the cause(s)
	with com	2	29b. Signature and little of certifier  30. Name and address of person who certifier  AAMN Chart	llu m	> (d	an N	De, Print)	D S78	303 BAUM	29d. Da	ite signed (Month, y 5 24	Day, Year)
**	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 0 20	105	egistrar's Sig	A A	perte					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene [ 1- State Registrar 5-9-05 Amend#8.Per FH PCC cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 2005 10:42 A M **Physician** 30 nael /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death County of Death Examiner Clinton Nursing Center rince Georges linton ena 6/Sex 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 1970 **Funeral** Hours 1 2 M 2 □ F 35 Yrs. Director 579-94-8821 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits Injury or other traumatic avant, the Mudical Exercities : ust be notified at Washington 1 Tes 2 No by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20002 or Itams 23a 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Raca - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) ock Pages 1 and 2 should be filed venent of Health and Mental Hygie ant: If itam 27 Is marked other! 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James inch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) bara & 70. 20002 20a. Method of Disposition 20c. Location - City or Town, State 1 EBurial 2 ☐ Cremation 3 ☐ Removal from State 5-7-2005 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal are of Funeral Service Licensee Name and Address of Facility
RUING WILLIAM
1813 Patomac AUE in & William Se Washington 167 De doors 23a. - art1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as care ac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) diorespir atou **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Tary, leading to firm ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dualto (or as a consequence of): The law requires that the death certificate be executed Va Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performed 21/10 tha Hospital or Attanding Physician: 25. Was case referred to medical examiner?

1 \( \text{Yes} \) 2 \( \text{No} \) No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) title of certifier 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

Arunatas

MAY 0 9 2005

31. Date filed (Month, Day, Year)

106 Fruing

Registrar's Signature

		1	For	partment of Health and Nertificate of Death		ene . No. 2005   7280
	Physicia		1. Decedent's Name (First, Middle, Last) William Ludtke		2. Date of Death	2000 5 Year 3. Time of Death 6:02 PM
	/Medic Examin	_	Aa. Facility Name (If not institution, give street and number)  National Lutheran Home	4b. City, Town, or Location of Death Rockville	)	4c. County of Death Montgomery
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthd. 213-03-2889 1 M 2 □ F 91 Yrs	Months Davs Hours Min.	8. Date of Birth (Month, Day) Sept. 15	(ear.) 913 9. Birthplace (State or Foreign Country) Maryland
	death with the Maryland ms 23a or 28a-f show		Usual Residence of Decedent  10a. State	Location Dckville		10d. Inside City Limits 1 ZXYes 2 ☐ No
	with the 3a or 28a It be noti	il Director	10e Street and Number 9701 - Veirs Dr.	10f. Zip Code 20850	100	g. Citizen of What Country? USA
		by Funerai	11. Marital Status  1 Never Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 ☒ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
1215-0036	within 72 hours after ene. than "natural", or Ita	Completed	(Specify only highest grade completed) (G	seedent's Usual Occupation ive kind of work done during most of wor e. DO NOT use retired) rinter	king	Sb. Kind of Business/Industry  Printing Co.
N	be filed tal Hygi d other event, I	To Be Co	17. Father's Name (First, Middle, Last) William P.F. Ludtke, Sr.		ne (First, Middle, Ma	
Maryland	nd 2 should lith and Men 27 is marke r traumatic	F	19a. Informant's Name/Relationship (Type, Print)  Mrs.Kristina Hughes-Executor-	ailing Address (Street and Number or Ru 9701 - Veirs Dr.,	Rockvil	City or Town, State, Zip Code) 1e, Md. 20850
altimore,	nit. Pages 1 ar artment of Hea ortant: If itam injury or otha		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disagraphy, Parkwood Parkwood	sposition (Name of crematory or other place) Od Cemetery 5/10	Date 20 0/2005	oc. Location - City or Town, State Baltimore, Md.
Balti	pernit. Pag Department Important: any njury o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Hysong Co. 6510-16th St.,	,NW,Wash	,,DC
	cate be executed Cate by executed Cate by executed Cate Cate Cate Cate Cate Cate Cate Cate	dical Examiner	23a. Part1. Enter the disease, or complications that cause it he death. Do not shock, or heart failure. List only one cause on such in e.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to for as a consequence of)  Due to (or as a consequence of)	e heart fa	îlure Îlure Deseas	Approximate Interval Between Onet and Death Owner and Death Ow
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	uires that II signed by ild be detac	d by Ph	Part II. Dther significant conditions consobuting to death but not resulting in the	ie underlying cause given in Part I.	1	cco use contribute to the cause of death?
Vital Records,	The law requir cate has been si page 2 should	Completed	. / /		24a. Was an autopsy perform 1 □ Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Vita	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Other	ath (Check only one	
Division of	Attending Physician: ir death. ector: After this certificaby the funeral director.	tion: To	27. Manner of Death 1 Matural 5 Pending 2 Accident   Ac	ne of 28c. Injury at	28d. Describe how	ce 6 Other (Specify) v injury occurred
Divisi	al or Atten after deat Directors of in by the	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Stre City or Town,	set and Number or Rural Route Number, State)
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Gertifying Physician: To the best of my knowledge, of the basis of examination and/of and manner stated.	leath occurred at the time, date and place or investigation, in my opinion, death occurred.	urred at the time, da	te and place, and due to the cause(s)
)	To th withir To th comp	Me	29b. Signature and title of certifier  Alel W. Carell	29c. License number 21726	29	d. Date signed (Month, Day, Year)  Nay 4, 2005
f	4)		30. Name and address of person who completed cause of death (Item 23a) (To Dr.Charles W. Karesh- 9701-V		ille,Md	,
	St Regist	ate rar	31. Date filed (Month, Day, Year)  MAY 1 0 2005	and I		

			Plea:	State of M				Health and M		_	ole.	1 77 /0 /	0.1
			1 - Stata Registrar			Ce	rtificate of	Death	Reg	. No: U	Jo	1721	o I
ı	Physicia /Medic		1. Decedent's Name (First, Middle Robert	, Last)	(	J.	Lynch		2. Date of Death Month May 8, 20	05 Day	Year	3. Time of D 11:56 A	
	Examin		4a. Facility Name (If not institution	-				r Location of Death		4c. County			
			5. Social Security Number		o /In ure	last birthday)	Forestvi	If Under 24 Hrs.	8. Date of Birth	Prince		e'S	Foreign
k	Funeral Director		143-145180 Usual Residence of Decedent	1. A 2 F	83	Yrs.	Months Days	Hours Min.	May 4, 192	2 (gar)	New Je	ν)	
	Maryland B-f show iffed at	ctor	10a. State 10b. County	George's		y, Town or Lo estvill			-		10	d. Inside City	
	h with the	al Dire	10e. Street and Number 6604 Nyack Place				10f. Zip Code 20747		10	g. Citizen of V USA	Vhat Counti	ry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic avent, it is modical Exam he must be notified at Once.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marr 3 ▼Widowed 4 □ Divorced	12. Was Decedent Armed Forces? ied 1 XXes 2 □ If Yes, Give Year or Dates:	•		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - America k, White, e Whit	tc.	
21215-0036	n 72 hoi "natura edical I	leted	15. Deceden (Specify only highes	t grade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	ing	3b. Kind of Bu	siness/Indu	ustry	
7	l withi	шо	Elementary/Secondary (0-12)	College (1-4or	5+)	Qualit	y Control S	Specialist		Federa	1 Gove	rnment	
and	ld be filed ental Hyg kad other ic avent,	To Be C	17. Father's Name (First, Middle, Peter Lynch	Last)				18. Mother's Nam Margaret	e (First, Middle, M McArdle	aiden Sumam	ie)		
Mary	12 shou n and M r is mar raumat	-	19a. Informant's Name/Relations					and Number or Rur		-		Code)	
ė,	1 and Health am 2		Robert J. Lynch /	SOII	20b. F	lace of Disp	osition (Name of			La 223 Dc. Location		vn, State	_
ě	ages ant of nt: If it		15 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S				matory or other pla eterans Cen	eteryMay 12	, 2005 CI	neltenha	m, Mary	yland	
Baltimore, Maryland	permit. F Departm Importar any injur		21. Signature uneral Service				2. Name and Addre	ess of Facility Ger ill Road Ox	orge P. Kal		ral Hon 2074	_	
Г			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each I	d the deat ine.					_		Approximate Interval Betwo Onset and De	reen
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Met	asta	tic Lur	ng Cancer					Oliset and De	eau)
S	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):							
Ē.		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as	a conseq	uence of):							
Ć,	le be executed ysician and e burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as	a conseq	uence of):							
68760,	cate be physicial the but	dical		d									
P.O. Box 6	he death certificate r the attending phys ched for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	I death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Dat Mo	te of deliver		ear
	law requires that the das been signed by the 2 should be detached	þ	Part II. Other significant condition Chronic O	ons contributing to death the bstructive I				ven in Part I.		acco use cont			
of Vital Records,	0 4 0	Completed	Atheroscl	erotic Cardi	Lovas	cular	Disease		24a. Was an autopsy perform	ed?	prior to com death?	sy findings a	vailable use of
ta	uclan: Th certificate rector, pag	0	25. Was case referred to medica	hrillation_				26. Place of Deat	1 ☐ Yes 2 th (Check only one		I □ Yes 2	2 U NO	
f Vi	d is	To B	examiner? 1 □ Yes 2 ②No	Hospital: 1 ☐ Inpat	ent 2	ER/Outpatie	ent 3 DOA	her: 4 Nursing Ho	ome <b>5XXX</b> Besider	ce 6 □Oth	er (Specify,	)	
	Jing Ph J. After thi funeral		27. Manner of Death  XXNatural 5 Pendir		ury ay Year)	28b. Time of Injury	Wo	ryat rk? ]Yes 2 ∐No	28d. Describe how	v injury occurr	red		
Division	f or Attanding after death. Diractor: After in by the fune	Certification:	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 200 Place of In	ijury - At h itc. <i>(Speci</i> i	ome, farm, s fy)	treet, factory, office		28f. Location (Str. City or Town,	eet and Numb State)	er or Rural	Route Numb	Θr,
	Hospital 4 hours Funeral ely filled	ledical Ce		ng Physician: To the best Exeminer: On the basis and manner s	of examina								
	To the within 2 To the complet	Me	29b. Signature and title of certifie		^		29c. Licen	se number	29	d. Date signe		Day, Year)	
			Danaid ?	Culled h	0		Do	02660	7	May 9,	2005		
2	(15)		30. Name and address of person  Edward Cullen						20745				
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 1 0 2	2. Regis	trar's Sign								
				The state of the s		100							

			1 - For State Registrar	State of	f Marylan	•			ealth ai	nd M	ental Hyg	jiene	005		72	82
	Physici /Medic		1. Decedent's Name (First, Middle MARY	L. LY	LES						2. Date of Dea Month APRIL	2 <sup>Day</sup> ,	200	5 1	Time of E	
	Examin Funeral	er	4a. Facility Name (If not institution  14508 Homeo  5. Social Security Number	erest Roa			If Unde	ilve r1Year		prin	C Data of Birth	I.	County of De IONTG 9. E			Foreign
ļ,	Director		218-24-0407  Usual Residence of Decedent  10a. State 10b. County	1□M <b>2CX</b> F	81	Yrs. y, Town or Lo	Months	Days	Hours	Min.	Month, Day	7,19	24	Mary	lan	d 
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show I.a Madical Exemiter mat Le matified at	rector		tgomery		-	lver	Code	ring			10g. Citiz	en of What	1	I □ Yes	
	death with	Funeral Director	14508 Homeo		dent Ever in U.		Was Dece		0906	in? (Spe	cify Yes or No- Rican, etc.)		U.S.	merican Ir	ndian,	
0036	nours after ural', or ite	by	1 ☐ Never Married 2 ☐ Marri 3 🏿 Widowed 4 ☐ Divorced	ed 1 □Yes If Yes, Giv Year or Da	2 <mark>∏</mark> No e		1 🗌 Yes	<b>2</b> ⁄2 №	Specify:	Puerto F	rican, etc.)		Black, W Specify:	Blac		
21215-0036	within 72 t iene. than "nate	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed) College (1	-4or 5+)	life. I	kind of wo DO NOT u	ork done a se retired,	luring most o				ontq.			hoo1
Maryland 2	uld be filed Mental Hyg irked other	To Be C	17. Father's Name (First, Middle, I						18. Mother	's Name	(First, Middle,	Maiden S				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show among injury or other traumatic event, it a Madical Examiner must be notified at Once.		19a. Informant's Name/Relations!  Charles J. I  20a. Method of Disposition  1√2 Burial 2 □ Cremation	yles, J	20b. P	634 Place of Dispo	O Da	maso me of other place	cus F	Road		ther	sbur	g,MI	20	882
Baltimore,	permit. Pag Department Importent: any injury once.		4 ☐ Donation 5 ☐ Other (S)	pecify)	vele MD	22	. Name a	nd Addres	s of Facility	Snc	//05 wden I on St.	-une	ral	Hom $\epsilon$	dM,	
	Pnysician /Medical		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a A	aused the deat ach line. Cute M or as a conseq	lyocar						rest,		Inte	prox 2 0 erval Betw set and De	een
	Examiner	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (	Oronar or as a conseq	uence of):									ears	
8760,	cate be executed physician and the burial-transit	Ical Examiner	that initiated events resulting in death) Last	Due to (	yperte oras a conseq iabete	uence of):			vascu	ıLar	Disea	ase		1	ars	
.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be delached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		irth 2 ☐ Feta ant at time of d	Ideath 3□	Ectopic p Other (s <sub>i</sub>					2	3d. Date of o	delivery Day	Ύ€	ar
ecords, P.	w requires that t been signed by should be detac	þ	Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the u	nderlying	cause give	en in Part I.		23e. Did to	bacco us		to the ca		
$\mathbf{\alpha}$	: The law requirate has been page 2 should	Completed								_	24a. Was a autop: perfor 1 🗆 Yes	sy med?	24b. Were prior 1 death	o comple	tion of car	
on of Vital	ding Physician: The th. After this certificate hi funeral director, page	tlon: To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  27. Manner of Death  1 ☒ Natural 5 ☐ Pendin 2 ☐ Accident investig	28a. Date of (Mont	npatient 2 of Injury	ER/Outpatien 28b. Time of Injury		28c. Injury Work	er: 4 🗌 Nurs	sing Hon	(Check only or ne 5 X Resid 8d. Describe h	ence 6		pecify)		
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification:	3 Suicide 6 Could r 4 Homicide determ	ot be 28e. Place	of Injury - At he	ome, farm, str (y)	eet, factor	y, office		2	8f. Location (S City or Tow		Number or	Rural Ro	ute Numb	er,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the Examiner: On the ba and mann	best of my kno asis of examina ner stated.	owledge, death	vestigation	n, in my op	oinion, death	l place, a	ed at the time, o	late and	olace, and c	lue to the	cause(s)	
)	i i i i i i i i i i i i i i i i i i i	Σ	29b. Signature and title of certifier	Lipe.	5	mo		c. License	)154	406		1	signed (Mo	-		_
_	V		30. Name and address of person  Cezar A. Lo	pez, M.	D. 18	3111 F	rino	ce P	hilir	o Dr	., 01:			2083		
	Sta Registr		31. Date filed (Month, Day, Year)	2005 R	egistrar's Signa	ature	de									

			1- For State of Maryland / Department of Health and Certificate of Death	d Mental H	ygiene Reg. No	000	17284
	Physici /Medio		Decedent's Name (First, Middle, Last)     KENNETH MAYBIN	2. Date of I Month May	Death Da	y Year 2005	3. Time of Death 5:40 A M
	Examin		4a. Facility Name (If not institution, give street and number) Holy Cross Hospital  4b. City, Town, or Location of D Silver Sprin	eath	4c.	. County of De.	
	Funeral Director		713 10 3232 A3 1 17 11s.	Hrs. 8. Date of E Min. (Month, ) Sept. 1	Birth Day, Year) 6, 195	9. Bost	irthplace (State or Foreign Country) COn, MA
	f ehow	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location Silver Spring				10d. Inside City Limits Yayes 2 No
	death with the Maryland ma 23a or 28a-f chow	Funeral Director	10e. Street and Number 14127 Castle Blvd. # 102 10f. Zip Code 20904	·	10g. Cit	tizen of What C	Country?
9500	int. Pages 1 and 2 should be filed within 72 hours after death with the Marylad southeast of Health and Mental Hygiene.  Settlement of Health and Mental Hygiene.  Interventing them 27 is marked other then "netural", or itama 23a or 28a-1 ehow injury or other traumatic event, the Medical Exams and interventional to indiffer at the marylad at the contract of the con	by Funera	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forcas?  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forcas?  1 Never No. If Yes, Sive I No. If Yes, Give I No. If Yes, Give I No. If Yes 2 No. If Yes 2 No. If Yes 2 No. If Yes 2 No. If Yes 2 No. If Yes 2 No. If Yes 2 No. If Yes 2 No. If Yes 2 No. If Yes 2 No. If Yes 2 No. If Yes 2 No. If Yes 2 No. If Yes 2 No. If Yes 2 No. If Yes 2 No. If Yes 2 No. If Yes 2 No. If Yes 2 No. If Yes 3 No. If Yes 4 No. If Yes 4 No. If Yes 4 No. If Yes 4 No. If Yes 4 No. If Yes 4 No. If Yes 5 No. If Yes 5 No. If Yes 5 No. If Yes 6 No. If Yes 7 No. If Yes 8 No. If Yes 8 No. If Yes 8 No. If Yes 8 No. If Yes 9 N	? (Specify Yes or I uerto Rican, etc.)	10-	14. Race - Am Black, Wh Specify:B1	ite, etc.
N-6171	within 72 not ene. then "neture the Wedical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 2+  16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)  Student	working	16b. K	ind of Busines	s/Industry
yland z	Mental Hygi Mental Hygi arkad othar atlc evant, t	To Be Co		Name (First, Midd yn Vi	le, Maiden rgin		Watson
, Mar	and 2 sno ealth and I m 27 le me		19a. Informant's Name/Relationship (Type, Print)  Rita Maybin, Wife  19b. Mailing Address (Street and Number of 14127 Castle Blvd)				
Dailimore	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any njury or other tra		20a. Method of Disposition  1  Burial 2X Cremation 3  Removal from State  1  Donation 5  Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Riverdale Pk. Crematory	0/2 <mark>005</mark>		roation - City o	
Dal	Deport Import any nj		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Biotrchi F.S. S14 Upsh			gton, DC	20018
	hysician /Medical		23a. Part1. Enter the fise set or complications that caused the death. Do not enter the mode of dying, such as care shock, or hear failur sist only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. SEPSIS  Due to (or as a consequence of):	diac or respiratory	arrest,		Approximate Interval Between Onset and Death Days
	It is taken sequites that the beautified by executed to the has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to ammodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	SYNDRO	ME		Years
O. DOX	the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   5   Other (specify)     9   Unknown   5   Other (specify)     1   1   1   1   1   1   1   1   1			23d. Date of de Month	elivery Day Year
cords, r.	been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Rectal Cancer		tobacco u		to the cause of death?
		Completed	Ascutes	24a. We aut per	s an opsy formed?	l prior to	utopsy findings available completion of cause of
A II a	rnyalcten. In this certificate ral director, pag	o Be	examilier?	Death (Check only	one)		acifu)
	After	Certification: T	27. Manner of Death  1 XNatural 5 Pending (Month, Day Year)  28a. Date of Injury (28b. Time of Injury Work?  2 Accident investigation  28a. Date of Injury (Month, Day Year)  M 1 Yes 2 No	28d. Describe			ouny
	to the mospital of Attending within 24 hospital of the Touris after death.  To the Funeral Director After completely filled in by the funer		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or T	own, State	)	lural Route Number,
:	in 24 hor the Fune pletely fi	ledical	29a. Certifier  (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place. Check only a medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated.	ace, and due to the	e cause(s) e, date and	and manner a I place, and du	s stated. e to the cause(s)
,	With Source	Σ	29b. Signature and title of certifier  D32332		29d. Dat 05,	te signed <i>(Mon</i> / 04 / 05	th, Day, Year)
	(4)		30. Name a d address of person who completed cause of death (Item 23a) (Type, Print)  Suresh K. Gupta, MD 9801 Georgia Ave. #220 Silver Spri	ng, MD.	2090	2	
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 0 9 2005				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 11:40 P<sup>M</sup> Novella McCree McCullough 2005 May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number **Funeral** Days 1 ☐ M 2 ☐XF 1913 Director 17, North Carolina 577-34-7678 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a State 10b County or 28a-f show the Medical Exeminer must be notified at 1 1 Yes 2 □ No Maryland Prince George's Glen Dale Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Items 23a 12500 Guinevere Road 20769 United States Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married African Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☑ No Specify Specify 3 ∰ Widowed 4 □ Divorced American natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygien Importent: If item 27 is marked other It any injury or other treumatic event, IIIs 2002. 6th Domestic Self-Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lizzie Grier Richard McCree 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara Cannon - Niece 12500 Guinevere Rd., Glen Dale, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Department 5 Other (Specify) Quantico National Cem. 5/11/2005 Triangle, VA 21. Signature of Muneral Service Licens 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Jause (Final disease or Andition Respired tore **Physician** resulting in death) /Medical Examiner 226 Sequentially list conditions, a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy 2 No 1 Yes 2 🗆 No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification; After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director; A investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 046998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3415 Hamilton ST MD 31. Date filed (Month, Day, Year) State **θ** 9 2005 Registrar

			1- State of Maryland / Dep	artment of Health and Mertificate of Death		iene 005	17286
		П	Decedent's Name (First, Middle, Last)		2. Date of Deat	h	3. Time of Death
	Physici /Medic		David Arthur Medwedeff		Month May	8 2005	3:05 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			12804 Kernel Circle	Bowie		Prince Ge	orge's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day,	reari Gou	place (State or Foreign Intry) Colombia
	Director		451-36-1702 TELM 2 76 Yrs.  Usual Residence of Decedent		Aug. 26	,1928 Sout	h America
	yland		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	a-1 st	tor	MD Prince George's	Bowie			1 X Yes 2 ☐ No
	or 28	Director	10e. Street and Number	10f. Zip Code	10	ng. Citizen of What Cou	intry?
	23a		12804 Kernel Circle	20715		USA	
	tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Agned Forces?	Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
36	filed within 72 hours after death with the Maryland Hygiene. kther than "natural", or Items 23a or 28a-1 show ant, the Medical Examinat must be notified at	by F	1 ☐ Never Married 2 ☑ Married 1 ဤ Yes 2 ☐ No 1949 — If Yes, Give 1953	1 ☐ Yes 2 ☒ No Specify:		Specify:Whit	
21215-0036	tural	edk	1/33	dent's Usual Occupation			
75	nin 72	piet	(Specify only highest grade completed) (Give	kind of work done during most of work DO NOT use retired)	ing	6b. Kind of Business/Ir	loustry
2	d with giene ar the	Completed		trical engineer		Aerospace ]	Industry
nd	al Hy I other	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name			
<u>Na</u>	should be and Mental marked o	To	David Ralph Medwedeff	Maria	del Car	men Pedrosa	1
Maryland	and and sm			ng Address (Street and Number or Rura			
	1 and 2 Health tem 27			Kernel Circle, Bo			
altimore,	Pages nent of H ant; If ite ury or ot		HE Durial 2 Liviernation 3 Linemoval from State	matory or other place)   05-10	J-05	Oc. Location - City or T	
<u>=</u>	it. Pa rtmer rtant njury			Memorial Gardens		avidsonvill	.e, Md.
Ba	permit. Pages Department of Important; If it any injury or o			2. Name and Address of Facility Bea 2512 NW Crain Hwy.	all Fune: Bowie		5
			23a. Part1. Enter the disease, or complications that caused the death. Do not en				Approximate
	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	11-14 - 1-			Interval Between Onset and Death
	/Medical		resulting in death)  a. Due to (or asia consequence of):	Heart Failure Artery Disea	3		
п	Examiner		Sequentially list conditions b. Cohonahy	Artery Disco	se		
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	and I-tran	Examin	cause (Disease or injury that initiated events resulting in death) Last C.  Due to (or as a consequence of):				
8760,	cate be executed physicien and the burial-transit		bue to (or as a consequence or).				
687	ficate physis the	edical	d				
Box	death certifi e attending id for use as	Z/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliv	arv
m.	death e atte	icia	in the past 12 months?  1 Yes 2 PNo 4 Pregnant at time of death 5[	Ectopic pregnancy Other (specify)		Month	Day Year
о. О		Physician/M	9 ☐ Unknown				
Ś	as this	by F	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
ecord	w require been si should t	ted	Chronic Kenal Failure		1 Tes	s 2 No 3 Prot	pably 4 Unknown
Ö	law law las be	Completed			24a. Was an autopsy		psy findings available impletion of cause of
E E	the law cate has page 2	Con			perform	ed? death?	2 No
Vital	Physician: The this certificate ral director, page	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one	)	
	shys this al dii	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatied  27. Manner of Death 28a. Date of Injury 28b. Time of		ne 5 Resider		y)
U <sub>O</sub>	ding F h. After funer	tion	1 ■ Natural 5 □ Pending (Month, Day Year) Injury	f 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe hov	v injury occurred	
Division of	after death after death Director: A	fica	3 Suicide 6 Could not be		28f Location (Stre	eet and Number or Rura	al Route Number
	al or A s after il Direct	Certification:	4 ☐ Homicide determined building, etc. (Specify)	oos, rastory, onloo	City or Town,	State)	riodie Namber,
	e Hospital 124 hours a e Funeral D letely filled		29a. Certifier  (Check only Check only 2 Medical Examiner: On the basis of examination and/or in	h occurred at the time, date and place, a	and due to the cau	use(s) and manner as s	tated.
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral Director.	Medical	one) and manner stated.				
	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	_	29b. Signature and title of certifier	29c. License number	1	d. Date signed (Month,	•
^		-	corus of Ruse	221837		1/24,0	9,2005
12	-(5/11)	,	30. Name and address of person who completed cause of death (Item 23a) (Type, Louis J. Larca, M.D. 7901 Maple	DZ7837 Auenue, Takon	Part Part	b Marila	A nomin
	Sta	e e	31. Date filed (Month, Day, Year)  21. Registrar's Signature	- 10e110e, / q col	mu iur	E, 11 KINY 10	ma 20412
	Registr		31. Date filed (Month, Day, Year)  MAY 0 9 2005  Registrar's Signature	de la			

UNKNOW Brenda	N J. Myer	:s	1- For Unpend Item Registrar	State of M 23a,27,28a	laryland/De -f per me	epartment of l C843 5-24 Certificate of	Health and N 1-05 tas	Mental Hy	giene	5 1	728	87
			Decedent's Name (First, Middle, L.					2. Date of Dea	ath		Time of D	Death
	Physici /Medio		Brenda Jea	n Myers				APRIL	26, 200	5 13	324	РМ
	Examin	er	<sup>4a</sup> BLACK OAK BOTTO	iye street and number,	)	McCOOLI	or Location of Death		4c. County of ALLEC	Death SANY	_	
295	Funeral Director		5. Social Security Number 6. 218-90-2480 Usual Residence of Decedent	7. Ag 1 ☐ M 2 ☒ F	ge (In yrs. last birtho 41 Yrs	Monthe Dave		8. Date of Birt (Month, Da October	<sup>h</sup> 2,1963	9. Birthplace <i>Country)</i> MID	(State or	Foreign
3)	yland iow		10a. State 10b. County		10c. City, Town o	r Location				10d. ir	nside City	y Limits
	death with the Maryland ims 23a or 28a-f show ir neat be notified at	ctor	MD Alle	gany	Cumbe	rland				1	☐ Yes	2 <b>X</b> No
	ith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?		
	s 23s		659 Greene Stree	12. Was Decedent	V Francis VI C	215			USA			
036	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Margical Exercities for all be notified at	by Funerai	11. Marital Status  1 ▼Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces	? [No	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 A No		Decity Yes or No- Dican, etc.)	Specify:	American In White, etc. Whi		
2-0	72 ho natur	eted	15. Decedent's (Specify only highest of		16a. D	ecedent's Usual Occup	pation	kin a	16b. Kind of Busi	ness/Industry	y	
2121	d within giene. er than *	Completed	Elementary/Secondary (0-12)	College (1-4or	5+1 -	Give kind of work done fe. DO NOT use retire cretary	d)	ung	Accoun	ting		
Maryland 21215-0036	ould be file Mental Hy arked oth	To Be (	17. Father's Name (First, Middle, La. Paul Woodrow Wil						Maiden Sumame) th Carro			
Mar	and 2 sho valth and n 27 is mu er trauma		19a. Informant's Name/Relationship Beverly Forman/s			Mailing Address <i>(Str</i> eet Bl Molitor				ate, Zip Code	(e)	
ore	ages 1 nt of He if item or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3		cemetery.	isposition (Name of crematory or other pla ake Cremat	ca)	Date	20c. Location - C			
Baltimore,	permit. Pages 1 and 2. Department of Health an important; if item 27 is any injury or other traugue.		* 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lic		Onesape	22. Name and Addre Fellows, 130 Speer	,			_		P.A.
			23a. Part1. Enter the disease, or co	mplications that cause	d the death. Do not	enter the mode of dyin	r KOAd, Ur	or respiratory ar	wn, Mary	App	roximate	
	Pnysician /Medical Examiner		shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a Drowning		:					rval Betwe et and De	
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as	s a consequence of)							
68760,	cate be executed oblysician and the burial-transit	dical Examine	that initiated events resulting in death) Last	cDue to (or as	s a consequence of):							
P.O. Box 6	ne death certifi the attending f hed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) □	у		23d. Date of Month		Ye	ear .
	juires that the signed by ald be detacted	by	Part II. Other significant conditions	contributing to death t	but not resulting in th	e underlying cause gw	ven in Part I.		bacco use contrib	ute to the cau	use of dea	
Recol	he law requir s has been si ge 2 should	Completed						24a. Was a autop	sy prid med? dea	ere autopsy fi or to completi ath?	ndings av	vailable use of
<u>ra</u>	yelclen: The lar is certificate has director, page 2	0	25. Was case referred to medical				26. Place of Deat			Yes 2□I	No	
Ξ	d is	To B	examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ Inpati	ent 2 ER/Outpa	atient 3 DOA Oth			ence 6XOther	(Specify)ΔT	SCF	'NF
o uo	ding Ph h. After th funeral		27. Manner of Death  1 Natural 5 Pending		ury <b>unk</b> 28b. Tim ay Year) Inju	e of <b>unk</b> 28c. Injur	ry at	28d. Describe h	ow injury occurred drowned			
Division of Vital Records,	i or Attendi after death. Director: A I in by the fu	Certification;	2 X Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of In building, e		, street, factory, office	193 2 (2)	28f. Location (S City or Tow	t treet and Number n, State) <b>Poton</b>	or Bural Bou	ite Numbe	er
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai Ce	29a. Certifier 1 Certifying f	Potomac Physician: To the best	of my knowledge, d	eath occurred at the tire investigation, in my d	me, date and place,	and due to the o	ause(s) and mann	er as stated.		
	To the within. To the comple	Med	29b. Signature and title of certifier	and manner st	-Pollat	29c. Licens 0. C.		2	29d. Date signed (i APRIL 2			
			30 Warne and address of person wh	o completed cause of		pe. Print) N STREET,	BALTIMORE	E,MARYLA	ND 21201			
	Sta		31. Date filed (Month, Day, Year)	6 2005	rar's Signature	1						

State of Maryland / Department of Health and Mental Hygiene U

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1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 **Physician** Murillo Rayo DE Gladira 2005 22 50 PM /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral**  Birthplece (State or Foreign Country) 1□M 2□F Hours 46 Director none Nicaraqua 12, 1958 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event. The Healest Exeminating the notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Salisbury Director Wicomico 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 235 Hazel Avenue Apt.2 21801 Completed by Funeral Nicaragua 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 → Married Baltimore, Maryland 21215-0036 <sup>1</sup>□X<sup>Yes</sup> <sup>2□ No</sup> Specify: Nicaragua Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) unknown Socorro Rayo Jarquin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fermin Murillo/Husband 235 Hazel Avenue Apt.2 Salisbury, Md21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Cemeterio Central 5/14/2005 Managua, Nicaragua 21. Signature of Funeral Service Licens PHILIP D.RINALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death **Physician** Cirrhosis Primary Biliary disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. attending physician use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 DEctopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Y Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4★ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No 1. Inpatient Certification: To 2 ER/Outpatient this 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of After 28d. Describe how injury occurred Injury s after dea. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) 5/1/2005 Sabrina N. Kratz MD 15949 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sabrina N. Kratz 22 South Greene Street Baltimore, Maryland 21201 31. Date filed (Month, Day, 32. Segistrar's Signature Year) State 0 6 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** JOSEPH : 19 AM may 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Baltimore BRUTIMORE CITY HOSPITAL JOHUS Holicians If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Oct. 15, 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F 1947 Philadelphia, PA 57 181-36-5364 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10a State 10b. County Show ns 23a or 28a-f shov 1 ☐ Yes 2X No Kennett Square **Funeral Director** Chester 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 Tussock Drive 19348 USA in than "natural", or items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: white Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hyglene. College (1-4or 5+) Elementary/Secondary (0-12) law firm 12 attorney . Pages 1 and 2 should be filed w tment of Health and Mental Hygien tant: If item 27 is marked other th jury or other traumatic event, "Li 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Joseph J. Malatesta Julia Pasquarella ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Tussock Drive, Kennett Square PA 19348 Susan Jin Davis/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any Injury or once. Birmingham-West Chester, PA 5/14/05 Lafayette Cem. 17/15/05 "Cofus Funeral Home, Ltd. 21. Signatu uneral Servi CC0442 Kennett Square PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) illes **Physician** LSCHEMIC /Medical Due to (or as a consequence of) **Examiner** LEUKEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-tran Due to (or as a consequence of): physician Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. the 9☐ Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II, Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed 1 ☐ Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death Check onli one Hospital: 2☐ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA ည 1 Yes 2 No 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: Injury \*\*Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier mo V0219 17/05

State Registrar

DHMH 17 Rev 1/2001

JOHNS HOPKINS

32. Registrar's Signature

600

HOSPITAL

N WOCFE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN KOETHE MA

31. Date filed (Month, Day, Year)

MAY 1 0 2005

Jennifer Martz 05-3110 AKG

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - For State Registrar		artment of Health and I tificate of Death	Reg. N	A B B
ysician Medical	Decedent's Name (First, Middle, Last)     Jennifer Marie MARTZ			2. Date of Death Month 5, 20	3. Time of Death   5:15 A M
caminer	4a. Facility Name (If not institution, give street and Route 5 & Bryantown		4b. City, Town, or Location of Death Bryantown		c. County of Death Charles
neral ector	5. Social Security Number 6. Sex 1 □ M 2 ▼	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year Nov. 9 19	9. Birthplace (State or Foreign Country)
4	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
be notified Director	Pennsylvania Frankli 10e. Street and Number	n Gre	eencastle	10g. C	1 ☐ Yes 2 🕅 No itizen of What Country?
rai D	15673 South Young Road		17225		U.S.A.
adical Exercises count be notified at oldered by Funeral Director	Arme  1 Never Married 2 Married 1 Yes	es 2 🕅 No	Was Oecedent of Hispanic Origin? (S. f Yes, specify Cuban, Mexican, Puert I ☐ Yes 2 ☑ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify:  White
t, the Madical Exe Completed by		(Give life. I	lent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king	Kind of Business/Industry
snt, 1	12 (	) ]	Ianager 18. Mother's Nan	Tr ne (First, Middle, Maide	raffic Control n Sumame)
	Joe Cook		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 Showe	
other traumatic	19a. Informant's Name/Relationship (Type, Print)  Carol Cook - Mother		ng Address (Street and Number or Ru N. Mulberry St.	ra <i>l Route Number, City</i> Hagerstown,	
	20a. Method of Disposition  1 Burial 2 XCremation 3 Removal fi  4 Donation 5 Other (Specify)	20b. Place of Dispo cemetery, cren	stion (Name of natory or other place)  vn Crematory 5/9	Date 20c. I	Location - City or Town, State gerstown, Maryland
any injury or once.	21. Signature of Funeral Service Licensee		Calena and Address of English:	Minnich Fun	
is the burial-transit te burial-transit te burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events c.	on each line.  Multiple I  a to (or as a consequence of):  a to (or as a consequence of):	njuvies		Approximate Interval Between Onset and Death
ached for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) No 9 \( \text{Unknown} \)		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
S S	Part II. Other significant conditions contributing	to death but not resulting in the u	nderlying cause given in Part I.		use contribute to the cause of death?
page 2				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Wes 2 \( \subseteq \text{No} \)
ector Be	25. Was case referred to medical examiner?  1 X Yes 2 No Hospital:	1  Inpatient 2 ER/Outpatier	Othor	th (Check only one) ome 5 Residence	6XXOther (Specify) at scene
the funeral craft	27. Manner of Death  1  Natural 5  Pending 2  Accident investigation	Month, Day Year)  28b. Time of Injury Injury 512	28c. Injury at Work?  ↑ Yes 2 □ No	28d. Describe how injured Pedestria	ury occurred in 5truck by notor
		Place of Injury - At home, farm, str uilding, etc. (Specify)  High way	n occurred at the time, date and place	Bryav	1.14
pletely filled edical C	(Check only 2 Medical Examiner: On t		vestigation, in my opinion, death occu		
Med	29b. Signature and title of certifier  Arol Halla	eand	29c. License number OCME		ate signed (Month, Day, Year) 5, 2005
_	30. Name and address of person who completed	cause of death (Item 23a) (Type,	111 Penn Street	Baltimore	, Maryland 21201
State	31. Date filed (Month, Day, Year) Q 2005	2. Registrar's Signature	1 1.		

			For State Registrar	Sta	ate of M	aryland / [		rtment tificate				lental Hy	giene	005	1729	9
	Physici /Medic		Decedent's Name (First, Middle Dorot	. ,	rginia	Meek						2. Date of De Month	Day (	l Year	3. Time of Dea	ith P M
	Examir	er	4a. Facility Name (If not institution	_				_		Location of	of Death			unty of Dea		
	Funeral		Atlantic Gene 5. Social Security Number	6. Sex		je (In yrs. last biri	(hday)	If Under	Berlii 1 Year	n If Under	24 Hrs.	8. Date of Bir		orces		raian
L	Director		216-30-0058 Usual Residence of Decedent	1□M 2			Yrs.	Months	Days	Hours	Min.	July I	ay, Year)	M	rthplace (State or Fo country)	reign
	yland how		10a. State 10b. County			10c. City, Town	n or Loc	ation							10d. Inside City Li	mits
	e Ma	Funeral Director	MD Worce	ester		Ocea	an C	City							1 ☐ Yes 2 <b>∑</b>	No
	with th	Dire	10e. Street and Number					10f. Zip					10g. Citizen	of What C	ountry?	
	eath v	erai	12528 Ocean G		as Decedent	Ever in LLS	12 14/		B42	i- O-i	nia? /Cn	ecify Yes or No	US	D	adama ta ata a	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If itam 27 is marked othar than "natural", or itams 23a or 28a-f show any injury or othar traumatic evant, If a Medical Exactiner must be notified at 200ce.	by	1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	ed 1 (	med Forces?  Yes 2 X  Yes, Give  aar or Dates:		lf '	Yes, speci	rfy Cubar	Specify:	i, Puerto	Rican, etc.)		Black, Whi		
21215-0036	in 72 ho n "natur de dical	Completed	15. Deceden (Specify only higher	t grade com	pleted)		(Give k	ent's Usual ind of worl O NOT use	k done di	urina mos	t of worki	ng	16b. Kind	of Business	s/Industry	
212	d with giene ar tha	Com	Elementary/Secondary (0-12)	Co	ollege (1-4or 5	5+)	Hor	mema	ker				Own	Home	•	
Maryland	be file ital Hy id oth evant	Be	17. Father's Name (First, Middle,	Last)								(First, Middle	, Maiden Sui	name)		
N S	hould d Men narke natic	P L	Clinton Tracey  19a. Informant's Name/Relations.	in Œ C	ain 43	401			/ .		lie N					
S	d 2 sl lth an 27 is r traur		Melody Burrs		ant)							l Route Numb				
ē,	s 1 an f Heal itam other		20a. Method of Disposition			20b. Place of	Disposi	ition (Nam	e of		y, c 5-II-	ocean (			Town, State	
altimore,	Page: nent o nt: if		1 X Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S		al from State	Maryl		atory or oti		Ł.		.05	Hurlo	ck M	Md	
alti	permit. Departmingorial Importal any inju		21. Signature of Funeral Service	icensee		,	22.	Name and	Address	s of Facilit	y Th	e Burk	page F	uner	al Home	
	90 5 6 6	0 (3)	Tacquelin	a J.	- Da	Bothy	108	8 Wil	liam	St.,	Ber	·lin, M	d. 218			
			23a. Part1. Enter the disease, or shock, or healt failure. List	complication only one cau	s that caused se on each li	d the death Donne.	ot enter	the mode	of dying	, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between	1
	Physician / /Medical	i n	Immediate Cause (Final disease or condition resulting in death)	a		Paner	ecut	0	Co	ince	R.				Onset and Death	1
	Examiner		in dodan,		Due to (or as	a consequence of	of):									
	7 6.	er	Sequentially list conditions, if any, leading to immediate	b	Due to (or as	a consequence o	of):							_		
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events													
Ó,	e exe	Ex	resulting in death) Last		Due to (or as	a consequence o	of):									
8760,	cate be executed physician and the burial-transit	dicai		d						· · · -	-		<del></del>			
9 x	that the death certificated by the attending properties as	/Me	IF FEMALE:	23c. If v	/es. outcome	of pregnancy								5		
Box	death s atter d for u	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 É	Live birth Pregnant at	2 Fetal death time of death		ctopic pre Other (spe					230.	Date of de Month	Day Year	
0.0	it the by the tacher	hys	9 Unknown	90	Unknown	100										
	Se Po es		Part II. Other significant condition	ns contributi	ng to death b	ut not resulting in	the und	derlying ca	use givei	n in Part I.		23e. Did t		-	the cause of death	
ord	v requir been si should	eted		·								10	Yes 2⊟N	o 3 □ Pi	robably 4 Unkno	own
Records,	has b	Completed										24a. Was autop	osy	prior to	utopsy findings availa completion of cause	able of
		e Co	25. Was case referred to medical									1 Yes	rmed? 2 ☐ No	death?	2 No	
Vital	Physician: this certificanal director,	0 8	examiner?	Hospita	ıl:	ent 2 ER/Out	nationt	3 DOA	Othou			(Check only one 5 Residue)		Other (Co-		
סר	ding Physin. After this funeral di	n: T	27. Manner of Death	28a	. Date of Inju (Month, Day				c. Injury Work?			8d. Describe I			CITY)	
30	Attanding It death. actor: After by the funer	catio	1 Natural 5 Pending investig	ation	(Monar, Da)	7 7 0 0 7	ijury	М		es 2 🗆 N	No					
Division of	or Attano after death Diractor: in by the	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ		e. Place of Inju- building, etc	ury - At home, far c. (Specify)	m, stree	et, factory,	office		2	81. Location (S City or Tox	Street and Nu vn. State)	ımber or Rı	ural Route Number,	
	To the Hospital or Attan within 24 hours after deat To the Funeral Diractor: completely filled in by the	edical C	29a. Certifier 1 Certifyin	Physician:	To the best of	of my knowledge, examination and	death o	occurred a	t the time	e, date and	d place, a	nd due to the	cause(s) and	manner as	s stated.	
	To the within 24	Med	one) 29b. Signature and title of certifier	ar	nd manner sta	ated.			License							
)	F N N		255. Oignature and title of certifier	11	7	2/1 -1	111	290.	1/1/	282			zou. Date sig	Jilea (Mont	h, Day, Year)	
			30. Name and address of person	vho complete	ed cause of d	eath (Item 23a)	Type. Pr	rint)	77	W )			51	8105	)	
عے	71		ROBERT	DUR	KIN	9733 H	FEA	CH IN	JAY	DKI	VE	BER	CIN!	MD	21811	
29	Sta Registr	1.0	31. Date filed (Month, Day, Year)	2005	32. Pigistra	eath (Item 23a) ( 9733   ar's Signature	4	de								

				aryland / Department of I Certificate of	Health and Mental Hy	•
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last)  ARCA LAST  4a. Facility Name (If not institution, give street and number)  258 39 50 60	MICKEY  4b. City, Town,	2. Date of De Month or Location of Death	The second second
	Funeral Director			e (In yrs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of Bir Hours Min. (Month, Da	9. Birthplace (State or Foreign
	72 hours after death with the Maryland neturel', or items 23a or 28e-1 show alsal Executiver sust be neithed at	Director	10a. State 10b. County  MD TALBOT  10e. Street and Number	10c. City, Town or Location  EASTON  10f. Zip Code	1601	10d. Inside City Limits  XXYes 2 □ No  10g. Citizen of What Country?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygione. Important: if item 27 is marked other than "neturel; or items 23s or 28e-f show any injury or other treumatic event, the Modical Exacting 1 and the natitied at ange.	Completed by Funeral Director	28839 JASPER LANE  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Armed Forces? 1 Yes 20 Mily Yes, Give Year or Dates:	Ever in U.S. 13. Was Decedent of I	Hispanic Origin? (Specify Yes or No an, Mexican, Puerto Rican, etc.)	USA 14. Race - American Indian, Black, White, etc.  Specify: WHITE
21215-0036	ed within 72 ho ygiene. ner than "netur. it, I're Modical I.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  College (1-4or 5	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire ENVIRONMENTA	during most of working d) LIST	16b. Kind of Business/Industry  NON-PROFIT  ORGANIZATION
Maryland	should be fill of Mental Himarked oth	To Be	17. Father's Name (First, Middle, Last)  HARVEY STANLEY  19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address /Street	18. Mother's Name (First, Middle, UNKNOWN and Number or Rural Route Number	
	jes 1 and 2 sof Health ar if item 27 is or other treu		FRANK T. MICKEY/SON  20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State		OOD DRIVE, BETHE	
Baltimore,	permit. Pag Department Importent: any injury o		14 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee  105eph M. Osthowski C	CHESAPEAKE CREMAT  22. Name and Addre FELLOWS, H		STEVENSVILLE, MD  AM FUNERAL HOME PA
760,	Physician /Medical Examiner popularial-itansit	cal Examiner	23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	the death. Do not enter the mode of dvi		
P.O. Box 687		Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1	2 ☐ Fetal death 3 ☐ Ectopic pregnance	y	23d. Date of delivery Month Day Year
Records, P.	requ	Completed by Ph	Part II. Other significant conditions contributing to death be Hyperfeurive Cardicoral Christian Objective hung	ut not resulting in the underlying cause go reclar Deserve with C Disease	Trestrue Tadan 101	an 24b. Were autopsy findings available prior to completion of cause of
of Vital	Physicien: this certificanal director.	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatie:  27. Manney of Death  28a. Date of Injur (Month, Day)	y 28b. Time of 28c, Injur	1 ☐ Yes  26. Place of Death (Check only of the check only of the check only of the check only of the check only of the check only of the check only of the check only of the check only of the check only of the check on the che	· · · · · · · · · · · · · · · · · · ·
Division	or Attendin after death. Director: Af in by the fur	Certification:	2 Accident investigation	M 1 □	Yes 2 □ No	Street and Number or Rural Route Number, m, State)
<b>-</b>	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune.	Medical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the basis of and manner sta	examination and/or investigation, in my of	me, date and place, and due to the opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
)	Within To th	W	29b. Signature and title of certifier  William Hood  30. Name and address of person who completed cause of de	7	8715	29d. Date signed ( <i>Month, Day, Year</i> )  5   5   2005
	Sta Registr		WILLIAM H WOOD	J FO ( D	utchmans Lan	e EXAGNIMD 21601

			For State	ricasc	State o		d / Depa	artment o		and M	ental Hyg	iene	0.5	17293
			Registrar  1. Decedent's Nam	ne (First, Middle 1.	ast)			runouto	OI DOG!	·	2. Date of Deal	eg. Né.~ 💛 t		3. Time of Death
	Physici	an				т					Month	Day	Year	
1	/Medic		4a. Facility Name (	MARGARET				4b Ciby Tox	wn, or Location	of Death	May	4c. County	05 (of Death	2014
2	Examin	er			al Med		asse	40. Oity, 101	< n/ich	Link		1/	come	·0
<i>t</i> -			TenInsula 5. Social Security N	Vumber 6		7. Age (In yrs.	last birthday)	If Under 1 Y	ear If Unde	or 24 Hrs.	8. Date of Birth		9 Birthr	place (State or Foreign
DO	Funeral Director		215-28-4		1□ M 2XF	76	Yrs.		ays Hours	Min.	8. Date of Birth (Month, Day, JAN 11,	1929	Cour MAR	place (State or Foreign htry) RYLAND
7		1	Usual Residence of								01211 119	1323	111.11	IIIIIII
10	ylanc now		10a. State	10b. County		10c. Cit	y, Town or Lo	ocation					1	10d. Inside City Limits
5	the Marylan r 28e-f show nutified at	ţ	MD	DOR	CHESTER	Н	URLOCK	(						1X Yes 2 No
à	or 28¢	irec	10e. Street and Nu					10f. Zip Co	ode		1	0g. Citizen of \	What Cour	ntry?
. 0	hours after death with the Maryland tural', or Items 23a or 28e-f show al Examinal must be notified at	Funeral Director	45 DELA	WARE AVE	., APT 6			216	43			U	SA	
B	deat ms	ner	11. Marital Status		12. Was Dece	edent Ever in U. orces?	.S. 13.	Was Deceden	t of Hispanic C	rigin? (Spe	cify Yes or No- Rican, etc.)		ce - Americ	
S O	after or Ite		1 🔀 Never Mari	ried 2 Married	1 ☐ Yes	2 X No			No Specif		noun, sto.)		v: WHI	
$N$ $\stackrel{\sim}{\mathbf{S}}$	ours Frail,	d by	3 Widowed	4 Divorced	Year or D	ates:		100 2,4	, 110 Opoon,	,. 		3pecii)	y. WILL	
5-0	72	Completed	(Spe	15. Decedent's licity only highest g	Education rade completed)		16a. Dece (Give	dent's Usual C	occupation done during more tired)	ost of workir	ng	16b. Kind of B	usiness/In	dustry
21	within 7	idn	Elementary/Sec		College (	1-4or 5+)								
2 2	be filed with tal Hygiene. d other than event, the N		12	(First Adidate Area	0		SALES	S AUDIT		hada Nama	(First, Middle, I	RET.		
2 Ind	be fi	Be	17. Father's Name	HENRY MA		יםי					E. COULE		110)	
Mayshay/ 55 e, Maryland 21215-0036	d 2 should be filed with and Mental Hygiene. 7 ie marked other that traumatic event, the	10				OK.	10h Maile	- Address /C					Cto to Zin	Code
4 ह	12 sho h and 7 le mu Iraumi			lame/Relationship		משי					Route Number			
	s 1 and f Health item 2 other t		20a. Method of Dis	IA A. HU	KS1/S1S1		_	SUX 13		-	ST., SE	20c. Location -		
300	& ° = 5		1 🔀 Burial 2	Cremation 3		State	emetery, cre	matory or othe	r place)					
が音	nit. Page artment o ortant: If injury or			5 Other (Spec		WC					12-2005	EASTO	N, MA	RYLAND
Baltimore,	permit Depar Impor any in once.		21. Signature of F	uneral Service Lic			FÏ	ELLOWS	Address of Fac HELFE	NBEIN_	& NEWNA	M FUNE	RAL F	IOME PA
5	HE E W G		~10	the disease, or co	100	RLERS							01	Approximate
_			shock, or he	art failure. List onl	y one cause on e	each line.	Do not en			0	ole		,	Interval Between Onset and Death
	Physician		Immediate Cause disease or conditi resulting in death)	on	(		res	LED	CVU		ace	100		
	/Medical Examiner		Toouning in double,	•	Due to	(or as a conseq	uence of):	NN	in					
		-	Sequentially list of	onditions,	b. Due to	(or as a conseq	uence of):							
	be:	Examiner	Sequentially list of any, leading to it cause. Enter Und Cause (Disease of that initiated event	lerlying r injury	240 10	SSS	6	07	eil	6	S			
	and all-train	xar	that initiated event resulting in death)	ts Last	c	(or as a conseq	uence of):							
760,	ate be executed nysician and he burial-transit	calE		, a	les.	1 Pr	non	the						
687	icate phys				O									
×	Attending Physician: The law requires that the death certificat r death. •ctor: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was deceded	ot pregnant		tcome of pregna						23d. Da	ite of delive	ery
B	atter after i for i	ciar	in the past 12	2 months?		ointh 2 ☐ Feta nant at time of d		⊒Ectopic pregr ⊒ Other <i>(speci</i>				Mo	onth	Day Year
o.	t the de by the a tached	ys	9 Unknow		9□ Unkn	own								
٠	es that igned b	by PI	Part II. Other sign	ificant conditions	contributing to d	eath but not res	ulting in the u	inderlying caus	se given in Par	t 1.	23e. Did tol	pacco use con	tribute to th	he cause of death?
rds	quires n sign ald be	q p									1 □ Y	s 2000	3 🗌 Prot	pably 4 □Unknown
Ö	w require been significant	Completed									24a. Was a	n 24b.	Were auto	opsy findings available
Re	The law ate has page 2	Juc									autops	ned?	death?	mpletion of cause of
a	ician: Th certificate rector, pag		25. Was case refe	erred to medical			-		26 Pla	ce of Death	(Check only on	1	1 🗆 Yes	2   100
<u> </u>	ysician: iis certific director,	o Be	examiner?	No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DOA	Other		ne 5 Reside		ner (Specif	(v)
Division of Vital Records, P.O. Box	ding Phys n. After this funeral di	n: T	27. Manner of Dea		28a. Date		28b. Time o		Injury at Work?		28d. Describe ho			
<u>.</u>	nding I ith. r: After e funer	atio	1 Accident	5 Pending investigation		iii, Day 16ai)	Injury	м	1 Yes 2	□No				
<u>×</u> :	Attendi	ific	3 Suicide 4 Homicide	6 Could not determine	208. Place	e of Injury - At h	ome, farm, st	reet, factory, o	ffice	2	28f. Location (SI City or Town		ber or Rum	al Route Number,
Ö	To the Hospital or Attend within 24 hours after death To the Euneral Director: completely filled in by the	Certification:	4 _ Nomiolea		build	ing, etc. (opoci	<b>y</b> /			1.40	ony or . om	,, 0.1107		
_	To the Hospital within 24 hours a To the Funeral I completely filled		29a. Certifier (Check only		Physician: To the aminer: On the b									
100	he Hin 24 he Fi	edical	one)	2   Medical Ex		iner etated.	LITOTI ATTOVOT II							` '
1.	To t	Σ	29b. Signature an	d title of certifier	1/1/5	Poar	W	29c. L	icense numbe	-700	2	9d. Date signe	id (Month,	
				Jr-	0010	,	/ /		1) Z )	20	/	5/	181	5
/	7-1		30. Name and add	dress of person wh	o completed cau	se of death (Iter	n 23a) (Type,	Print)	<b>-</b> /		112			1321
(_	5/		John N	Iclean	100 E	Cari	0115	st. 5	alistr	ry,	nD a	71801		
		ate	31. Date filed (Mo	Inth, Day, Year)	325 32G	Registrar's Signa	ature	, man						
	Regist	rar		mai + > Ci		AND AND AND AND AND AND AND AND AND AND	AL AND THE REAL PROPERTY.	10 M						

DHMH 17 Rev 1/2001

55# 215.28-4059

			1 - For State of Marylan	nd / Department of Health and Mental   Certificate of Death	Hygiene
	par pr		Decedent's Name (First, Middle, Last)	2. Date o	Death 3. Time of Death
	Physici		James Richard McFadden	Month May	9, 2005 11:39 P M
	/Medio Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Exami	iei	Homewood At Crumland Farms	Frederick	Frederick
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.		Birth 9. Birthplace (State or Foreign Country)
	Director		224-20-2935 1XM 2□F	81 Yrs. Months Days Hours Min. (Month	16,1923 Virginia
	ס		Usual Residence of Decedent		
	rylan how		10a. State 10b. County 10c. Cit	y, Town or Location	10d. Inside City Limits
	Ma Ma	cto	Maryland Frederick	Frederick	1 Yes 2 No
	or 28	)ire	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	filed within 72 hours after death with the Maryland Hygiene. thar than "natural", or items 23e or 28e-f show thar than "hadles Exercilies franti fer millfied at int, it a Medical Exercilies frantified at	Funeral Director	909 Mill Pond Road	21701	United States
	e ms	inei	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	.S. 13. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	r No- 14. Race - American Indian, Black, White, etc.
9	or it	F	1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:	Specific
21215-0036	ural',	d by	3 Wildowed 4 Divorced Year or Dates:		wnite
5	"nat	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)	16b. Kind of Business/Industry
12	withir ne. then	mp	Elementary/Secondary (0-12) College (1-4or 5+)		D-411 C
	iled v lygie thar i		17. Father's Name (First, Middle, Last)	Accountant  18. Mother's Name (First, Min	Railroad Company
and	ntal h	Be			
Ž	should nd Men marke umatic	To	James Clayton McFadden  19a. Informant's Name/Relationship (Type, Print)	Mary Alena 19b. Mailing Address (Street and Number or Rural Route N	
Maryland	C1 10 m 00		Doris McFadden / Wife	909 Mill Pond Rd. / Frederi	
	1 and Health Bm 27 ther to			Place of Disposition (Name of Date	20c. Location - City or Town, State
Baltimore,	ages of of or o		1 Burial 2 □ Cremation 3 □ Removal from State	cemetery, crematory or other place)	
ij	t. Partmer			int Olivet Cemetery 05/12/2005	
Bal	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee		r Funeral Homes, P.A.
	402 60		Baymond Seleson	1621 Opossumtown Pike /	
			23a. Part 1. Enter the disease, or complications that caused the deat shock of heart failure. List only one cause on each line.	n. Do not enter the mode of dying, such as cardiac or respirate	ry arrest, Approximate Interval Between Onset and Death
	Physician		tmmediate Cause (Final disease or condition resulting in death)	lar taclingerdia	minufes
	/Medical Examiner		Due to (or as a conseq	uence of):  Head Disease	
j.		١	Sequentially list conditions,		years
	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	derice orj.	•
	icate be executed physician and s the burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a conseq	uence of):	
8760,	be exician	Ical E			
87	physicate sthe	edica	d.		
9 x	eath certific attending pl	/Me	IF FEMALE: 23c. If yes, outcome of pregna	ancy	and David Addition
Box	atten atten for us	ian	in the past 12 months?	death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
	the de	200	1 Yes 2 No		
$\sim$		>	9 ☐ Unknown		
P.0	that the	Physician/M			Did tobacco use contribute to the cause of death?
<b>Q</b> _	ires that the de signed by the a d be detached to	by	Part II. Other significant conditions contributing to death but not res	culting in the underlying cause given in Part I. 23e. [	
<b>Q</b> _	requires that the period of th	by		culting in the underlying cause given in Part I. 23e. T	☐ Yes 2元 No 3☐ Probably 4☐ Unknown
<b>Q</b> _	aw requires is been sign 2 should be	by	Part II. Other significant conditions contributing to death but not res	ulting in the underlying cause given in Part I. 23e. 1	Yes 2 No 3 Probably 4 Unknown  Vas an utopsy  24b. Were autopsy findings available prior to completion of cause of
Records, P	The ate h		Part II. Other significant conditions contributing to death but not res  Pseudomembranous Colu	ulting in the underlying cause given in Part I. 23e. 1	☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown  Was an ultopsy enformed?  24b. Were autopsy findings available prior to completion of cause of death?
Records, P	The ate h	Be Completed by	Part II. Other significant conditions contributing to death but not res  Pseudomembranous Colu  25. Was case referred to medical examiner?	ulting in the underlying cause given in Part I. 23e. [  24a. [  25. Place of Death (Check of	Yes 21 No 3 Probably 4 Unknown  Was an utopsy serformed? es 21 No 1 Yes 2 No
Vital Records, P	The ate h	To Be Completed by	Part II. Other significant conditions contributing to death but not res  Pseudomembranous Colis  25. Was case referred to medical examiner?  1   Yes 2   No   Hospital: 1   Inpatient 2	24a. V  26. Place of Death (Check of Death)  ER/Outpatient 3 DOA  Other: 4 Nursing Home 5	Yes 21 No 3 Probably 4 Unknown  Was an ulopsy findings available prior to completion of cause of death? ass 21 No 1 Yes 2 No  No nity one)  Residence 6 Other (Specify)
of Vital Records, P	The ate h	To Be Completed by	Part II. Other significant conditions contributing to death but not res  Pseudomembyanous Colic  25. Was case referred to medical examiner?  1 Yes 2 No  1 Inpatient 2  27. Manner of Death 1 Yes 2 No 28a. Date of Injury (Month, Day Year)	24a. \\ 24a. \\ 24a. \\ 25a. Place of Death (Check of Death)  28b. Time of Injury  28c. Injury at Vork?	Yes 21 No 3 Probably 4 Unknown  Was an utopsy serformed? es 21 No 1 Yes 2 No No No No No No No No No No No No No
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of Vital Records, P	or Attanding Physician: The ifter death. Director: Atter this certificate his by the funeral director, page	Certification: To Be Completed by	Part II. Other significant conditions contributing to death but not res  Pseudomembranous Colic  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined  28a. Date of Injury (Month, Day Year)  28b. Place of Injury - At he building, etc. (Specification of Check only 2 Medical Examiner: On the basis of examinar.	24a. 2  24a. 2  24a. 2  25. Place of Death (Check or Death)  26. Place of Death (Check or Death)  27. Place of Death (Check or Death)  28b. Time of Injury Mark (Check or Death)  28c. Injury at Work?  M 28c. Injury at Work?  1	Yes 21 No 3 Probably 4 Unknown  Vas an utopsy enformed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No  No nly one)  Residence 6 Other (Specify)  ibe how injury occurred  on (Street and Number or Rural Route Number, Town, State)  the cause(s) and manner as stated, me, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
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Division of Vital Records, P.O. Box 68760,

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar		Cei	rtificate of	Death		Reg. No.	
		1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea	ith 2005	3: Time of Death
Physici /Medic		Alcide Pierre Mas	ssillon				MAY	6 2005	8145AM
Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	Location of Death		4c. County of Dea	ath
		Doctors Hospital			Lanham			Prince G	
Funeral		5. Social Security Number 6. Se	DM 20E	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Da)	y, Year) 9. Bi	rthplace (State or Foreign Country)
Director		579-52-7839 Usual Residence of Decedent	80	) ,,,,,			01/25/1	1925 Hai	<u>iti                                   </u>
yland		10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
Man 9-f sh	to	MD Prince Ge	eorge's I	Lanham					1 X Yes 2 □ No
th the	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
th will	<b>Funeral Director</b>	7513 Newburg Drive	2		20706			United Sta	ites
r dea	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13. \	Was Decedent of H	ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
s afte	by Fi	1 ☐ Never Married 2 ፟ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 2 No If Yes, Give		1 ☐ Yes 2 🕅 No	Specify:		Specify: B	
be filed within 72 hours after death with the Maryland Ital Hygiene. Ital Hygiene. Ital Hygiene. Italian "natural", or Items 23s or 28s-f show event, the Medical Examiner must be notified.	ed b	15. Decedent's Ed	Year or Dates:	16a Docer	ient's Usual Occup	ation		16b. Kind of Business	
n "na Medic	Completed	(Specify only highest gra-	de completed)	(Give	kind of work done of	during most of worki	ng	TOD. KING OF BUSINESS	unidustry
d with giene rrtha	mo:	Elementary/Secondary (0-12)	College (1-4or 5+)	Cab	Driver			Transporta	ation
e file al Hy I othe vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,		
Menta Menta arked	To	Decius Massillon				Nancy Ch	erichel		
and and the ma		19a. Informant's Name/Relationship (7	• • • • • • • • • • • • • • • • • • • •					r, City or Town, State,	Zip Code)
and lealth m 27		Viergella Massill				rive Lanh			
S = S		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐	Removal from State	*	natory or other plac	e)		20c. Location - City or	
tmen tant: ijury		`4 □ Donation 5 □ Other (Specify	)					Brentwood,	MD
permit. Pages I and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If liem 27 is marked other than "natural", or Items 23a or 28e-f show any injury of the traumatic event, the Medical Examiner must be nutified at once.		21. Signature of Funeral Service Licen	500	H	. Name and Addres ines—Rina	ss of Facility aldi Funer	al Home	e, Inc	
	-(	23a, Part L. Enter the disease, or comp	U						ng, MD 20904 Approximate
		23a. Part. Enter the disease, or comp shock, or heart allure. List only of Immediate Cause (Final	one cause on each line.	e e	or the mode of dyn.	g, such as cardiac o	/ lespiratory arr	051,	Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Due to (or as a co	Alyc	Marde	of Sug	ance	ear	The
Examiner			Due to (or as a co	onsequence ou:					
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. ————————————————————————————————————	ensequence of):					
cuted nd ransi	Examiner	that initiated events	C						
e exe		resulting in death) Last	Due to (or as a co	insequence of):					
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial transit	Medicai	•	d						
entifica ding pl		IF FEMALE:	22a If was autoemo et e						
eath ce attendi	ician	in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
at the de by the stached	Physic	1 Yes 2 No 9 Unknown	9□ Unknown	or death 5	Other (specify)				
res that igned by	by Pr	Part II. Other significant conditions co	entributing to death but no	ot resulting in the un	iderlying cause give	en in Part I.	23e. Did tol	pacco use contribute to	o the cause of death?
quires n sign	q p						1 🗆 Ye	es 2 No 3 P	robabiy 4 Winknown
aw requas been 2 should	Completed						24a. Wasa	n 24b. Were a	utoosy findings available
The la ate has page 2	omp						autops perforr	ned?// death?	utopsy findings available completion of cause of
	0	25. Was case referred to medical				26. Place of Death			3 2 □ No
ysician is certifi director	To B	examiner? 1  Yes 2 No	Hospital:	2 ER/Outpatient	3 □ DOA Othe			ence 6 Other (Spe	ecify)
ng Phys ter this neral di		27. Manne of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time of Injury	28c. Injury Work			ow injury occurred	
endir. sath. or: Af	atic	2 Accident investigation		,,,		res 2□No			
r Att ter de irect	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre	et, factory, office	2	8f. Location (St City or Town	reet and Number or Ri n, State)	ural Route Number,
oital c urs af urs af illed ii			1						
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exem	sician: To the best of mi	y knowledge, death mination and/or inv	occurred at the time estigation, in my op	e, date and place, a pinion, death occurre	nd due to the ca d at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
o the ithin 2 o the omple	Mec	29b. Signature and title of certifier	and manner stated.		29c. License			9d. Date signed (Mont	
F ≱ F 8		MA	1						
5	İ	30. Name and address of perkanduha o	ompleted cause of death	(Item 23a) (Type 5	Print)	2,007		, , , , ,	
-		30. Name and addless of person who o	(17) 57	15 MAIN	TKEET	50/72- 35	7 6-90	KEL, MO 3	20707
Sta	te	31. Date filed (Month, Day, Year)	3 Registrar's	Signature	N. s				-
Registra	ar	MAY 0 9 200	15 House	Dr. How				May 6, Je Kei, MO 3	

<b>t</b>	ı	1 - State AMEND#9, perINF5/1 Registrar	ate of Maryland / Dep.	artment of Health and rtificate of Death	Mental Hyg	ene g. No.2005	17296
Physic	cian	Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year	3. Time of Death
/Med		Sara Wright Maguire  4a. Facility Name (If not institution, give street	and number)	4b. City, Town, or Location of Deat	May 5,	4c. County of Death	12:10 P <sup>M</sup>
Exam	iner	Collingswood Nursing		Rockville	'	Montgomer	v
Funera	1	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day,		lace (State or Foreign
Directo	r	252-30-1445  Usual Residence of Decedent  10a. State   10b. County   10	2KIF 80 Yrs.		02/02/1	925 <del>Geor</del>	gia Carolina
laryla sho	ō	MD Montgomery	Rockvill				0d. Inside City Limits 1   Yes 2   No
the N	Funeral Director	10e. Street and Number	ROCKVIII	10f. Zip Code	1/	g. Citizen of What Cour	
Mith 3a or	D	3004 Windy Knoll Cou	rt	20850		U.S.A.	ney:
death ms 2;	era	11. Marital Status 12. W		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer		14. Race - Americ	an Indian,
urs efter	b	1 Never Married 2 Married 1	☐ Yes 2 🕅 No	If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 🔣 No Specify:	o Rican, etc.)	Black, White,  Specify: Whi	
IIIC Z I Z I 3-UU30  be filed within 72 hours efter death with the Maryland ttal Hygiene. d other then "neturel", or items 23a or 28a-f show event. The Madical Exerciter in ust be recitified at	Completed	15. Decedent's Education (Specify only highest grade com	npleted) (Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking	6b. Kind of Business/Ind	
filed with Hygiene ther the	Eo	Elementary/Secondary (0-12) C	ollege (1-4or 5+) Home	maker		Own Home	
ILYICING CIC	BeC	17. Father's Name (First, Middle, Last)	<u> </u>	18. Mother's Nar	ne (First, Middle, M	laiden Sumame)	
should be a marked o	To E	Porter Wright		Addie I	Bell Stal	lings	
T		19a. Informant's Name/Relationship (Турю, P Alfred John Maguire,	·	ng Address <i>(Street and Number or Rt</i> Windy Knoll Court			
permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre once.	0	20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Remove 1 ☐ Donation 5 ☐ Other (Specify)	altrom State	sition (Name of natory or other place)		Oc. Location - City or To	
Dalti. Departmit. Importe any inju		21. Signature of Funaral Service Licensee	25	2. Name and Address of Facility St. 40 Rockville Pike	imple Tri	bute	
cate be executed /Medical Examiner /Medical and the burial-transit		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Juse on each Wee.  Gastrointestinal  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				Interval Between Onset and Death Day
the death certificate y the attending physiched for use as the	Physician/Med	in the past 12 months?	□ Pregnant at time of death 5 [ □ Unknown	Ectopic pregnancy Other (specify)  nderlying cause given in Part I.	23e. Did toba	23d. Date of delive Month	Day Year
law requires t as been signe	ted by				1 🗆 Yes	: 2 □ No 3 □ Prob	abiy 4 <b>X</b> Unknown
The ate h	Completed				24a. Was an autopsy perform 1 Yes 2	prior to con	osy findings available npletion of cause of 2 \( \square\$ No
sicien: T sicentificat irector, pa	Be	25. Was case referred to medical examiner?	al:		th (Check only one	)	
ral dig	on: To	1 105 2 X	a. Date of Injury (Month, Day Year)  a. Date of Injury (Month, Day Year)  a. □ ER/Outpatier 28b. Time or Injury		ome 5 Resider 28d. Describe how	ce 6 Other (Specify vinjury occurred	")
or Attender deat Director: in by the	Certification:	2 Accident investigation	e. Place of Injury - At home, farm, str building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No eet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural State)	l Route Number,
To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edicai C	(Check only 2 Medical Examiner: C	: To the best of my knowledge, deat In the basis of examination and/or in nd manner stated.	n occurred at the time, date and place restigation, in my opinion, death occu	, and due to the cat rred at the time, dat	use(s) and manner as state and place, and due to	ated. the cause(s)
To th within To th comp	Me	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Month, L	Day, Year)
7		) The	John -	D20148	M	ay 6, 2005	
(		30. Name and address of person who complete	ted cause of death (Item 23a) (Type,				
		Steven Dolinsky, MD,	911 Russell Aven	ue, Gaithersburg,	Maryland	1 20879	

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** Adila Munoz 12:45 P 6, May 2005 /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 14, 1914 9. Birthplace (State or Foreign Country)
Puerto Rico 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months Hours Min 1 ☐ M 2 🔀 F 582-03-9779 91 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State rel', or Itams 23a or 28a-f show Examirer roust be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1812 Pelling Court 20905 Puerto Rico Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1₺Yes 2□No Specify: Puerto Rican Specify: White 3 ₩ Widowed 4 Divorced "naturel". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) or other traumatic event, the Mudicial 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "ne eny injury or other traumatic event, Te Me. 18, 2006. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alfredo Munoz Amelia Munoz 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1812 Pelling Court, Silver Spring, MD 20905 Ralph Jimenez/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition May Daio. 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 2005 4 □ Donation 5 □ Other (Specify)

21. Signature of Funeral Service in ansee Gate of Heaven Cemetery Silver Spring, Maryland Francis J. Coillins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 ches amely 23a. Part1. Enter the disease, or complications that coursed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pulmonary Embolism 5 Days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit s bean signad by the attending physician and should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical d IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 I ive birth 2 Fetal death in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔁 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page this certificate 2**X** No 1 ☐ Yes Attending Physicien: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 Tes 2 No Certification; To 1 Xinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 T Homicide ò Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29b. Signature and title of certifier D60038 dathe \_ M.B 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Forest alen Road, Silverspring, MD Padmalatha. R. moole 1500 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 10 2005 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		•	1 - For State Registrar	State of Ma	ryland / Depa		of Health a of Death	and Me		giene 0 0 5	17298
	D1		1. Decedent's Name (First, Middle, Last					1	. Date of Dea Month _	Day V	3. Time of Death
1	Physicia /Medic		Kenneth Evan	Markel			<del></del>		May 5,		12:04 A M
	Examin		4a. Facility Name (If not institution, give				wn, or Location of	of Death		4c. County of I	Death
			Suburban Hospita  5. Social Security Number 6. Se		(In yrs. last birthday)	Bet If Under 1	hesda Year   If Under:	24 Hrs.   g	Date of Rid	Montgo	
	Funeral Director		10	X / Age	43 Yrs.		ays Hours	Min.	. Date of Birti (Month, Day		Birthplace (State or Foreign Country) New York
			056-54-8715 Usual Residence of Decedent		43	L			Sept.	1, 1901	New TOTK
	nyland how		10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	e Ma	cto	Maryland Montgome	ery	Betheso	1					1 Yes 2 No
	vith th	by Funeral Director	10e. Street and Number			10f. Zip Co				10g. Citizen of Wha	
	s 23s	erai	9116 Kittery Lane	12. Was Decedent 8	ever in IIS 12	208		gin? (Speci	fy Vac or No.	U. S. A	American Indian,
	item inerr	Į,	11. Marital Status  1 □ Never Married 2X Married	Armed Forces?	lo		nt of Hispanic Ori Cuban, Mexican	n, Puerto Ri	can, etc.)		White, etc.
920	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀	No Specify:			Specify: W	hite
21215-0036	within 72 hours after death with the Maryland ene. then "returel", or items 23a or 28a-f show the Medical Examinar must be notified at	Completed	15. Decedent's Edi (Specify only highest grad	ucation		dent's Usual (	Occupation done during mos	t of working	,	16b. Kind of Buşin	ess/Industry
21	ithly see " Need	nple.	Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use	retired)			D 1.	6 F.
21	led w lygien lygien lyer th		47 Fabrus Alland (Fine Adiddle Local)	5+	E3	cecutiv		ode Namo (	Eiret Middle	Maiden Sumame)	& Finance
and	tal H	Be	17. Father's Name (First, Middle, Last)  Carl G. Markel						ottlie		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene if Health and Mental Hygiene item 27 is marked other then "neture!", or items 23a or 28a-f show other treumatic event, I're Medical Exactinar must be notified at	<sup>2</sup>	19a. Informant's Name/Relationship (T	voe Print)	19b. Maili	na Address (S	1			er, City or Town, Sta	ite, Zip Code)
_ ∑	th an the number of the number		Iris M. Markel - V							Maryland	20817
ē,	f Hea f Hea item othe		20a. Method of Disposition		20b. Place of Dispo cemetery, cre	osition (Name	of er place)	Da		20c. Location - Cit	
E	Pages 1 and 2 should be filed within nent of Health and Mental Hygiene.  mir. If Item 27 Is marked other then in: If Item 27 Is marked other then in yor other treumatic event, Item New York.		¹X Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,		Mount Leb			/6/20	05 .	Adelphi,	Maryland
Baltimore,	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service Licens	See 04	2:	2. Name and	Address of Facilit	ty oro M	omoria	1 Chapala	Tne
<u>m</u>	89888		Oonald (.)	XXXXXX	myer 1	170 Roc	kville	Pike,	Rocky	ille, Mar	, Inc. yland 20852
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of					cardiac or	respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	n Cardiac	Arrest	-				Immediate
	/Medical Examiner		Tossing in south,		a consequence of):						
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Ather Due to (or as	osclerosis a consequence of):	5					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C							
ó	an an irial-tr	Exa	resulting in death) Last	Due to (or as	a consequence of):						
3760,	death certificate be executed e attending physician and of for use as the burial-transit	licai	(	d							
x 68	entific ling p	Physician/Med	IF FEMALE:	22a Ifusa sutsama	of coordinate						
Вох	ath cattend	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3	□Ectopic preg □ Other (spec				23d. Date of Month	f delivery Day Year
o.	that the death ed by the atte detached for	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	time of death 3	_ Other (spec	y)		*		74
<u>α</u>	law requires that the as been signed by th 2 should be detache	y Ph	Part II. Other significant conditions co	ontributing to death be	ut not resulting in the u	ınderlying cau	se given in Part I		23e. Did to	obacco use contribu	ite to the cause of death?
Records,	quires n sign	ed by	Atrial Fibrillat	ion, Card	iomegaly				101	res 2X No 3	☐ Probably 4 ☐Unknown
00	aw require s been si 2 should I	piet							24a. Was		re autopsy findings available r to completion of cause of
Re	ding Physicien: The lav n. After this certificate has funeral director, page 2	Completed							perfo	rmed? dea	
ita	sten: ertifica	Be	25. Was case referred to medical examiner?					of Death	Check only o	ne)	
of Vital	Physicien: r this certific ral director.	၉	1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatie						dence 6 Other	(Specify)
	After Annerg	io	27. Manner of Death 1 △ Natural 5 ☐ Pending	28a. Date of Injui (Month, Da)	Year) 28b. Time of Injury	of 280	c. Injury at Work? 1 ☐ Yes 2 ☐		ia. Describe i	now injury occurred	
isio	Attending r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be		ury - At home, farm, st				If. Location (S	Street and Number	or Rural Route Number,
Division	after Dire	Certification;	4 ☐ Homicide determined	building, etc	c. (Specify)				City or Tov	vn, State)	
0	To the Hospitei or Attenc within 24 hours after death To the Funerei Director: completely filled in by the	aic	29a. Certifier 1X Certifying Phy	ysician: To the best	of my knowledge, dea	th occurred at	the time, date ar	nd place, ar	d due to the	cause(s) and mann	er as stated.
Po	he Ho n 24 I he Fu pletely	edical	(Check only 2 Medical Exam	niner: On the basis of and manner sta	examination and/or in ited.	ivestigation, ir	n my opinion, dea	ath occurred	at the time,	date and place, and	due to the cause(s)
	To the to the total	Σ	29b. Signature and title of certifier	111			License number			29d. Date signed (/	
•	12		* WAS MANY	2 WY		D	29229			May 5, 2	
	C	Approximately and a second	30. Name and address of person who o				И	720	Ob	Chara M	1 2085/
			Martin Kanovsky 31. Date filed (Month, Day, Year)	y, M. D. 5.	530 Wiscon ar's Signature	sin Av	enue, #	/30,	Cnevy	chase, Mo	1. 20074
	Sta Registi			105 Bour	ar's Signature						

			For State Registrar	State of Man		artment of He rtificate of D			ene g. No.	
	Physici		1. Decedent's Name (First, Middle, Last) Addie Louise Nordh				4	2. Date of Death Month 2		3. Time of Death 08:10 a M
	/Medio	er	4a. Facility Name (If not institution, give s Chester River Man	or		4b. City, Town, or  Ches	Location of Death stertown If Under 24 Hrs.	8. Date of Birth	4c. County of Death Kent	place (State or Foreign
	Funeral Director		210-14-9140	7. Age (/	n yrs. last birthday) 82 Yrs.	Months Days	Hours Min.	May 30,	1922 MD	place (State or Foreign entry)
	Maryland f show	tor	Usual Residence of Decedent	11	oc. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🖔 No
	with the	Direc	10e. Street and Number 21962 Kelly Park F	aod.		10f. Zip Code 2166	51	10	g. Citizen of What Cou USA	ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If item 27 is marked other than "natural; or items 23e or 28e-f show important: If item 27 is marked other than "natural be natified at once.	by Funeral Director		12. Was Decedent Eve Armed Forces? 1		Was Decedent of His If Yes, specify Cubar		cify Yes or No- Rican, etc.)	14. Race · Ameri Black, White, Specify: Who	etc.
21215-0036	within 72 hou ene. than "natura he Modical E	Completed	15. Decedent's Education (Specify only highest grade (Specify only highest grade (0-12) 1 2	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d OO NOT use retired, Homemaker	luring most of workir	ng 1	6b. Kind of Business/Ir  Own Hot	
	ould be filed Mental Hygi arked other	To Be Co	17. Father's Name (First, Middle, Last) Harry A. Thompson				18. Mother's Name Addie		laiden Sumame)	
Maryland	and 2 should ealth and Men n 27 Is marke her traumatic	-	19a. Informant's Name/Relationship (T) Michael Nordhoff (s)		19b. Maili 23299	ng Address (Street a	and Number or Rura Branch Ro	oad, Che	City or Town, State, Zij stertown, l	M D 21620
Baltimore,	Pages 1 and the sant: If item arry or other		20a. Method of Disposition 1 □ Buriai 2 ☒ Cremation 3 □ F 1 □ Donation 5 □ Other (Specify)			osition (Name of matory or other place se Cremati	9)		Stevensvil	
Balti	permit. Departr imports any inju		21. Signature of Funeral Service Licens	elferla			Helfenbeir Road, Che			Home P.A.
	Pnysician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the cause on each tine.	WRI F	CATIONS	g, such as cardiac o	STAGE	st,	Approximate Interval Between Onset and Death
	Examiner	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a c						
8760,	icate be executed physician and s the burial-transit	dical Examiner	that initiated events resulting in death) Last	Due to (or as a c	consequence of):					
.O. Box 68	death certifi e attending I ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent premant in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deliv Month	rery Day Year
9	26 Dec	by	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	underlying cause give	en in Part I.		s 2 No 3 Pro	
Records,	e law has b	Completed	PACETS	Dijens	e			24a. Was ar autopsy perform 1 \( \text{Yes} \) 2	prior to condeath?	opsy findings available ompletion of cause of
of Vital	Physician: The this certificate ral director, pag	To Be	T Yes 2 No		2 ER/Outpatie		4 Nursing Hor	me 5 🗆 Reside	nce 6 Other (Special winjury occurred	ify)
Division o	fe fe	Certification:	27. Man er of Death  1 Autural  2 Accident investigation  3 Suicide 6 Could not be	28a. Date of Injury (Month, Day )	rear) Injury	M 1 🗆	k? Yes 2 □No	28f. Location (Str	reet and Number or Rus	al Route Number,
Div	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 Homicide determined  29a. Certifier 1 Certifying Phy	building, etc.	(Specify) my knowledge, dea	th occurred at the tin	ne, date and place,	City or Town	use(s) and manner as	stated.
	o the Hos ithin 24 h o the Fur ompletely	Medicai	(Check only 2 Medical Examone)  29b Signature and title of Certifier	iner: On the basis of e and manner state	xamination and/or in	29c. License	pinion, death occurr	ed at the time, da	ate and place, and due	to the cause(s)
	F ≯F 8		15als	empleted sauss of day	7),		36058		5/10/0	5
			30. Name and address of person who of Rateick Shanaha	MD 130	Speci Ro	m BidisB	Chester	town Mi	21099	
	St	ate	31. Date Jiled (Month, Day, Year)	2005 Negral	o oignature	And the				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Mayonth, 2003 **Physician** 15:00 рм Mary Ann Elizabeth Nicholson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Chestertown Nursing & Rehabilitation Kent Chestertown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March | 12, 1920 Birthplace (State or Foreign
 Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F 85 216-12-1036 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Items 23e or 28a-f show the Medical Examiner must be potified at 1 ☐ Yes 2X No MD Chestertown Queen Anne's Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21620 108 River Road USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othe any injury or other treumetic event, 90ce. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lewis Newsome Margaret Walker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 25193 Porter's Grove Road, Worton, MD 21678 Joyce Nicholson/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Still Pond Cemetery May 11, 2005 Still Pond, M D \* 4 □ Donation 5 □ Other (Specify) P.A. Name and Address of Facility Fillows, Helfenbein Rewnam Funeral Hiller P.A. 21. Signature of Funeral Service License Kick & 23a. Part1. Enter the disease, or compile tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only of cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VENTRICULAR ARHYTHMIA <2 min Physician /Medical Due to (or as a consequence of) **Examiner** CARDIOVASCULAR DISTANTE THERUS CLERLOTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injuried events.) Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last physician ar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical use as t the attending IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death in the past 12 months? jo Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à CEREPROVASCULAR 3 ☐ Probably 4 ☐Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No this certificate has page 1 Yes 2K) No 1 ☐ Yes or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. injury at Work? funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Diractor: in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide the Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 1/2001

0 2005



who completed cause of death (Item 23a) (Type Print)

Spær

ame and address

Date filed (Month, Day, Year)

			1 - For State Registrar	State of I	Marylar		artmen rtificat			nd Me		giene Reg. No.	005	7:	301
	Physic /Medi		1. Decedent's Name (First, Middle, L Herman Grey								Date of Dea Month May		2005 <sup>ar</sup>		of Death 46 Au.
	Examii		4a. Facility Name (If not institution, g  Larkin Chase, Ho  5. Social Security Number  6.	arborside	Healt	h Care	·	wie	Location of I		Date of Birth	Pr	ince Geo	orge's	
	Funeral Director		246-26-2680 Usual Residence of Decedent	1 <b>X</b> M 2□ F	93	Yrs.	Months	Days		Min.	Date of Birth (Month, Day 1/6/11	Year)		emont,	e or Foreign N.C.
	ith the Marylar or 28a-f show	Director	Md. 10b. County P.G.	Desires		ty, Town or Lo SOWie	10f. Zip					10g. Citi:	zen of What Cor		City Limits es 2 ☐ No
5-0036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or Items 23a or 28a-f show event. I're Modical Examiner must be mullined at	by Funeral	13313 Yorkton  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1XT]Yes 2 If Yes, Give Year or Date	s?	45	I □ Yes	No No al Occupa	spanic Origin n, Mexican, F Specify:		y Yes or No- an, etc.)		U.S.A.  14. Race - Ameri Black, White Specify: Black	etc. ack	
2121		Completed	(Specify only highest g Elementary/Secondary (0-12)	2 Yrs.	or 5+)	life. L	OO NOT us	se retired,	ve Spe	ecial		U.S.	0.0.D. Govern	ment	
yland	should be filed and Mental Hygi Is marked other aumatic event.	To Be	17. Father's Name (First, Middle, Las Joseph News	ome					Fanr	nie S					
e, Mar	ges 1 and 2 should t of Heelth and Men If Item 27 Is marks or other traumatic		19a. Informant's Name/Relationship Beatrice B. Newso	(Type, Print) Ome/Wife	20h I	13313	York	town	Dr.,	Bowi	e, Md.	20	Town, State, Zi		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Heelth s Important: If Item 27 Is any injury or other tra <u>once.</u>		20a. Method of Disposition  1 Method of Disposition  1 Method of Disposition  1 Other (Spectary Control of Spectary ther Control of Special O	ify)	10	Place of Dispondentery, cremotery	Mem.	Cem	. 5/	Date /10/0 & SO: /e.,N	5	Suit	cation - City or T cland, M cngton,	id.	20019
8760,	The law requires that the death certificate be executed  State of the attending physician and state of the attending physi	dical Examiner	shock, or heart failure. List onlimmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Conges  Due to (or b. Corona  Due to (or c. Atrial	tive as a consequence of the con	tery Di	sease							Interval B On set and	etween d Death
P.O. Box 6	that the death certific ed by the attending p detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	Il death 3 🗆	Ectopic pro					2	3d. Date of deliv Month	ery Day	Year
	w requires that I been signed by should be deta	ed by Ph	Part II. Other significant conditions Prostate Cano		but not res	ulting in the un	derlying ca	ause give	n in Part I.			acco us	se contribute to t	the cause of	
al Reco	: The law requires the has been page 2 should be the shoul	Completed	General Debil	ity.					-	_	24a. Was a autops perform	y	24b. Were auto prior to co death? 1 \( \subseteq \text{Yes}	mpletion of	s available cause of
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours effer death.  To the Funeral Director: After this certificete his completely filled in by the funeral director, page	Certification; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending  2 Accident investigative  3 Suicide 6 Could not	be on Disease	njury Day Year)	ER/Outpatient 28b. Time of Injury	M 2	8c. Injury Work 1 🗆 Y	r. 4 X Nursii	ing Home 28d.	Describe ho	ence 6 ow injury			
N N	spital or Attendours effer death nours effer death noral Director: / filled in by the		4 ☐ Homicide determined	building,	etc. (Specif	y)  wledge, death	occurred a	at the time	e, date and n	place and	due to the ca	n, State)	Number or Run	stated	
Δ	To the Hospital within 24 hours e To the Funeral I completely filled	Medical	29b. Signature and title of certifier	iminer: On the basis and manner	of examina stated.	ition and/or inv	estigation,	in my op License D452	nion, death on the number	occurred a	t the time, da	ate and pate	signed (Month,	o the cause( Day, Year)	(s)
*	(4) Sta	te.	30. Name and address of person who Adebowale Ajay 31. Date filed (Month, Day, Year)	i, M.D.	5201 C	Greenbe.	lt Ro	ad S	uite #	∮ U–1!	5,Colle	ege	Park,Md	. 2074	10
	Registr	-	MAY 1 n 200	5 Maria	J 18	Some									

		1 - State Registrar	Clate of IVI	aryland / Dep <i>Ce</i>		of Death	a Mental II	Reg. No.	15 173	02
Physic	an	1. Decedent's Name (First, Middle, Las	1)				2. Date of D	Death Day	3. Time of	-
/Medi		NICKOLAS F. NAZAR					may	5 20	005 1208	, M
Exami	ner	4a. Facility Name (If not institution, give	street and number)	fal		Easton	eath	_	albot	
Funeral		Social Security Number     6. Security Number		e (In yrs. last birthday)	If Under 1 Y	Year If Under 24 h	Irs. 8. Date of E		9. Birthplace (State o Country) NEW JERS	r Foreigi
Director		154-16-8736 Tusual Residence of Decedent		83 Yrs.			FEB 16	1922	NEW JERS	EY_
within 72 hours after death with the Maryland ene. than "neturel", or Itams 23a or 28e-1 show he Mcdical Examiner i ust be notified at	_	10a. State 10b. County		10c. City, Town or Lo			,		10d. Inside Cit	-
28e-f	ectc	MD TALE	SOT	OXF		ada .		10a Citizen of		
a or	급	28114 ALMSHOUSE	BOAD.		10f. Zip Co	21654		10g. Citizen of		
ns 23	eral	11. Marital Status	12. Was Decedent	Ever in U.S. 13	Was Deceden		(Specify Yes or N	1	USA ce - American Indian,	
or result and Mental hygiene. itam 27 ia marked othar than "netural", or Itams 23a or 28e-1 show other traumatic evant, the Medical Examinerust by notified at	by Funeral Director	1 □ Never Married 2 □ Married  3 ◯ Widowed 4 □ Divorced	Armed Forces?  1 AYes 2 1  If Yes, Give Year or Dates:	No	If Yes, specify 1 ☐ Yes 2	nt of Hispanic Origin? Cuban, Mexican, Pu No Specify:	ierto Rican, etc.)	Bla Specii	ick, White, etc.	
netura Scal E	eted	15. Decedent's Ed (Specify only highest grad	ucation	16a. Dece	dent's Usual O	Occupation done during most of	working	16b. Kind of B	Business/Industry	
land marked other than "	Completed	Elementary/Secondary (0-12)	College (1-4or	i+) life.	DO NOT use r	retired) ASSISTAN'		C&P T	EI EDIIONE	
othar ant,		17. Father's Name (First, Middle, Last)	1	ENGIN	EEKING		L Name (First, Middi		ELEPHONE	
ked c	To Be	JOHN NAZARE					E SIVOLEI		-,	
a mar	-	19a. Informant's Name/Relationship (T				Street and Number or			, State, Zip Code)	
tam 27 other tr		NICKOLAS F. NAZAR	E, JR/SON			D ROAD, OX	KFORD MD	21654		
r itar or oth		20a. Method of Disposition  1  Burial 2  Cremation 3	Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other	of or place)	Date	20c. Location	- City or Town, State	
Important: If itam 27 any injury or other tr once		* 4 ☐ Donation 5 ☐ Other (Specify,	)	CHESAPEAK			. 5/7/200	5 STEVI	ENSVILLE, M	D
Important: I any injury o once		21. Signature of Funeral Service Licens		) F		Address of Facility • HELFENBI	EIN & NEV	NAM FUNI	ERAL HOME PA	A
		23a. Part1. Enter the disease, or comp	MERCE	RON 2	00 S. I	HARRISON S	ST EASTON	I, MD 216	501	
		shock, or heart failure. List only o	ne cause on each li	ne.	er the mode of	or dying, such as card	nac or respiratory	arrest,	Approximate Interval Betv Onset and D	ween
ician dical		disease or condition resulting in death)	a. Ven mo	a consequence of):	nial	nen			Minut	es
niner			Acasto	a consequence very:	ndial	march	- ·		Money	65
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequance of):	0 - 00,					
and I-transit	xaminer	Cause (Disease or injury that initiated events	Staphy	baccu	s sep	Sis			Days	
an and rial-trar	ш	resulting in death) Last	Due to (or as	a consequence of):						
physician as the burial	Physician/Medical		d							
27 rd	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				22d Da	to of dollars	
Į.	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		2 Fetal death 3	Ectopic pregn Other (specif				ite of delivery onth Day Y	'ear
by me	hysl	9 Unknown	9□ Unknown		``					
gned l	by P	Part II. Other significant conditions co	ntributing to death b	ut not resulting in the u	nderlying caus	se given in Part I.	23e. Did	tobacco use con	tribute to the cause of de	eath?
should	ted t	Anemia					_ 1[	Yes 2□No	3 □ Probably 4	laknown
N	Completed						24a. Wa aut	opsy	Were autopsy findings a prior to completion of ca	vailable use of
	Con						per 1 ☐ Yes		death? 1 ☐ Yes 2 🔀 o	
certificate ector, pag	Be	25. Was case referred to medical examiner?	despital: a			04	Death Check on			
al dir	2	1 Yes 2 No	Hospital: 1) Inpatie		53272270	Other: 4 Nursing	g Home 5 Res	sidence 6 Oth		
Vfte.	tlon	1 Actident 5 Pending investigation	(Month, Da	Year) Injury	M 200.	Work? 1 ☐ Yes 2 ☐ No	280. Describe	rilow injury occur	160	
Diractor: A	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, farm, str c. (Specify)				(Street and Numb own, State)	per or Rural Route Numb	oer,
fille		29a. Certifier 1 Certifying Phy	sician: To the best	of my knowledge, deat	h occurred at the	the time, date and pla	ace, and due to the	e cause(s) and ma	anner as stated. and due to the cause(s)	
To tha Fur completely	<b>l</b> edical	one)	and manner sta	ited.			Scalled at the time			
COU	Σ	29b. Signature and title of certifier	dyanat	^^′	29c. Li	icense number	119	_	d (Month, Day, Year)	
		Jashmi Vai	21.00 - a H	202 [V]	V)   1/6		4	MAY 5	2005	

10+IVA) State

31. Date filed (Month, Day, Year) MAY 1 0 2995

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Registrar

			1 - For State Registrar		aryland / Der		t of H	lealth ar			e) 0.05	17303
п	Dhusia	-	1. Decedent's Name (First, Middle, Last,	)					2. Date Mor	e of Death	ay Year	3. Time of Death
	Physic /Medi		Helen R. Nic	odemus					Ma			1:55 P M
	Exami	ner	4a. Facility Name (If not institution, give	street and number,		4b. City,	Town, or	Location of	Death	4.	c. County of Death	
			Glade Valley N	ursing Ho	ome	Wa	1ker	sville	2		Frederi	ck
	Funeral		5. Social Security Number 6. Se:	7. Ag	ge (In yrs. last birthda	y) If Under Months	1 Year Days	If Under 24 Hours	4 Hrs. 8. Date Min. (Mor	of Birth oth, Day, Year	9. Birth	place (State or Foreign ntry)
	Director		212-12-7309	JM ZLXIF	85 Yrs.	101011010	Days	7.0013	Mar	ch 25,	1920 Mary	land
	pu		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or							
	anyla sho	-			Toc. City, Town or	Location						10d. Inside City Limits
	Ba-f	Director	Maryland Frederic	k		reder						1 ☐ Yes 2 🔀 No
	with th	Dire	10e. Street and Number			10f. Zip	Code			10g. C	itizen of What Cou	ntry?
	death with the Maryland ms 23a or 28a-f show	rai	2500 Waterside D					701			nited Sta	ates
	er de tams	Funerai		12. Was Decedent Armed Forces?	,	. Was Deced If Yes, spec	ent of Hi	ispanic Origin In, Mexican, I	n? (Specify Yes Puerto Rican, e	s or No-	14. Race - America Black, White,	can Indian, etc.
36	s afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 If Yes, Give	No	1 ☐ Yes	2 <b>X</b> No	Specify:				White
5-0036	72 hours after natural', or Ita			Year or Dates:								
5	nation and	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Giv	edent's Usua e kind of wo	rk done d	during most o	of working	16b. F	Cind of Business/In	dustry
2121	within	m_	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT us					D 114 G	
2	Hygid Hygid Ithar Int,	ပိ	12 17. Father's Name (First, Middle, Last)			Sec.	reta		s Name (First, I		Public So	chool
ano	ntal l	To Be							, , ,			
Z	2 should ba filed withir and Mental Hygiene. is markad othar than aumatic evant, the My	ĭ	Andrew Roderick	O-1-11	401.44		10.		iry Vio			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar I Health and Mental Hygiene. itiam 27 is marked othar than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examilant must be notified at		19a. Informant's Name/Relationship (Ty								or Town, State, Zip	•
	1 and 1 ealt 1 m 2		Edgar F. Nicodem	ıs / Husb	and 2500 20b. Place of Disp			e Driv	-		, Marylar	
Or	ges t of h ff ita or of		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, cr	ematory or o	ther plac	e) M:	Date av 14.	20c. L	ocation - City or To	own, State
Ë	men tant: jury		*4 ☐ Donation 5 ☐ Other (Specify)		Mt. Oliv	et Cen	netei	су	ay 14, 2005	Fre	derick, N	faryland
Baltimore,	permit. Pages 1 ar Department of Hea Important: if itam any injury or othal		21. Sign ture of Funeral Service License	90		22. Name an	d Addres	s of Facility	Stauff	er Fun	eral Home	es. P.A.
ш	g 0 = 9 g			*	1	.621 O <sub>J</sub>	ossi	umtown	Pike	Freder	ick, Mary	land 21702
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused te cause on each fi	d the death. Do not en	nter the mod	e of dying	g, such as ca	rdiac or respira	itory arrest,		Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	7.		: ~ /						Onset and Death
	/Medical		resulting in death)	Dug to (or as	a consequence of):	1100	-					4 112/2
	Examiner		O constitution for the state of									/
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of)							
	cutec	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
o o	an ar	EX	resulting in death) Last	Due to (or as	a consequence of):							
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cal		•								
Ö	tifica ig ph as th	ledi										
Вох	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome		O=					23d. Date of delive	ery
	deati	icia	in the past 12 months?	4☐ Pregnant at		□Ectopic pro □ Other (spo					Month	Day Year
0	that the de ed by the detached	hys	9 Unknown	9∐ Unknown							_	
9	es thai gned b	by P	Part II. Other significant conditions con	tributing to death b	ut not resulting in the	underlying ca	use give	n in Part I.	23e	. Did tobacco	use contribute to th	ne cause of death?
rds	quires n sign	d b	CONTESTIVE	hea	A 401	1400				1 ☐ Yes 2	No 3□ Prob	ably 4 Unknown
00	w requir been si should	ete		,		(			242	. Was an	24b Worn auto	psy findings available
Records,	he lav	Completed							_	autopsy performed2		npletion of cause of
-	Ician: The certificate ector, pag		00.144						1 🗆	Yes 2 No		2 No
Vital		Be	25. Was case referred to medical examiner?	ospital:			Othe		Death (Check			Motor year wa
of	Phys rthis ral di	. To	1 ☐ Yes 2 ☐ No ☐ ☐ 27. Manner of Death	1 Unpatie	ent 2 ER/Outpatie		M	4 Nursii			6 □Other (Specify	<i>'</i> )
n	ding F h. After funer	io	Natural 5 ☐ Pending	(Month, Da	y Year) Zob. Tille		Bc. Injury Work	?		cribe how inju	гу оссиггеа	
Division	Attendi er death. ractor: A by the fu	Certification;	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	20 a Place of Ini	una da barra da sa	M		′es 2□No		/0.		
<u>&gt;</u>	or A after Dirac in by	rtif	4 ☐ Homicide determined	building, et	ury - At home, farm, s c. (Specify)	ireet, factory,	office		City	or Town, State	nd Number or Rura e)	i Houte Number,
Ц	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the		00-0-4						1			
	Hos Hos Fun Fun	ica	Check only 2 Medical Examin	ier: On the pasis of	of my knowledge, dea examination and/or i	th occurred a nvestigation,	at the time in my op	e, date and p inion, death c	place, and due to occurred at the	time, date and	) and manner as st d place, and due to	ated. the cause(s)
	the tha mple	Medical		and mailner st								
	T W C	-	29b. Signature and title of certifier	177		290.	License		_		te signed (Month, I	
<b>X</b>			<u> </u>	en, My	),	C	リス	164	3	5	10/05	
	9		30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (Type	, Print)			_	0		
			65 C Thon	mas 💉	mor non	) D	/	Fre	deno	/c 6	10/05 ND 2	1702
	Sta Registr		31. Date filed (Month, Day, Year) 1 2	.005 32. Redistr	ar's Signature	Sand	.0					, -

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 4, 2:45 P M GENE I. NAMOVICZ MAY 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Min. 1□M 2√F Director 357-24-6705 77 JULY 11, ILLINOIS Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itams 23a or 28e-f ahov ingr must be notified at 1 Yes 2 No Be Completed by Funeral Director MD. MONTGOMERY TAKOMA PARK 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 333 LINCOLN AVE. 20912 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) LIBRARIAN parmit. Pagas 1 and 2 should be filed w
Department of Health and Mental Hygier
Important: If item 27 is markad other tt
eny injury or other traumatic avant. Its
once. LIBRARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ ERNTE TNYART PAULINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STANLEY B. NAMOVICZ/HUSBAND 333 LINCOLN AVE., TAKOMA PARK, MD. 20912 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 5-6-2005 RIVERDALE, MD. 21. Signature of Funeral Servic Vicensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in eight line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Wee /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate ba executed Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a Wasan autopsy Zheimer 2 No 1 Yes or Attending Physician: ours after death.

naral Diractor: After this certifica
filled in by the funeral director, i Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Certification: To 3□ DOA 27. Manner of Ceath Date of Injury (Month, Day 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Tyes 2 No 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 3 chuse of death (Item 23a) (Type, Print) 32 Registrar's Signature 31. Date filed (Month, Day, Year, State 0 9 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** RUTHANNE 2:50 OSHEROFF MAY 3 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SUBURBAN HOSPITAL **BETHESDA** MONTGOMERY | Months | Days | Hours | Min. | May 12, 19 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (Stete or Foreign
 Country) 1 □ M 2 F 81 Yrs 192-12-6481 PENNSÝLVANIA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1X Yes 2 □ No Directo MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1801 E. JEFFERSON ST., #207 20852 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No δ Specify: 3 ☐ Widowed 4 🕅 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 RESEARCH ASSISTANT U.S. GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SAMUEL STEINBERG (UNASCERTAINABLE) 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6649 FAIRFAX RD., CHEVY CHASE, MD 20815
ace of Disposition (Name of Date 20c. Location - City MAURI L. OSHEROFF/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 X Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) KING DAVID MEM. GDNS. 05/05/2005 FALLS CHURCH, VIRGINIA 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LONGESTIVE CARMONYOPATHY Due to (or as a consequence of) PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 21☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: ≯ Inpatient 2 □ ER/Outpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 3□ DOA 27. Manner of Death
1 DNatural
2 Accident 28c. Injury at Work? 28a. Late of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🔲 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Physician /Medical **Examiner** The law requires that the death certificate be executed burial-transit 68760, as Box for use signed by the a o ۵. Records, page 2 s Vital of To the Hospitel or Attending PI
within 24 hours after death.
To the Funerel Director: After the completely filled in by the funeral Division Medical

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ent: If item 27 is marked other than "naturel", or Items 23s or 28s-1 show ury ocother treumatic event, the Medical Eners in at most be notified at

permit. Pages 1 and – Department of Health an Importent: If item 27 is any injury ocother tree once.

Maryland 21215-0036

Baltimore,

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osheroff,

M.D. 11119 GOSWANI . Registrar's Signature 31. Date filed (Month, Day, Year) State 10 2005 Registrar

nowa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

(Check only one)

29b. Signature and title of certifier

M.D.

29c. License number

D-27660

ROCKVILLE PIKE

29d. Date signed (Month, Day, Year)

ROCKUIUE MD 120852

5/3/05

			For State Registrar	State of Ma	arytano		artment of F tificate of I				eg. No.	df	
	Obveisi		Decedent's Name (First, Middle, La.	st)					2	2. Date of Deat Month	h 401	Year	3. Time of Death
	Physici /Medio	al	Cynthia Eileen				4b. City. Town, or	- Laastia-		May		005	5:10 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, given Paint Branch Assi		no		Adelphi		or Death		Prince		rge's
	Funeral		5. Social Security Number 6. S	ex 7. Age		ast birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8	B. Date of Birth (Month, Day,	1		lace (State or Foreign try)
	Director		090-48-5832	□M 2XF	73	3 Yrs.	WONUIS Days	Hodis		Aug 25,			ados
	ow ow		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					1	0d. Inside City Limits
	e-f sh	ctor	New York Nassau		Roos	sevelt							1 ☐ Yes 2 ☑ No
	or 28	Director	10e. Street and Number				10f. Zip Code			10	0g. Citizen of W	hat Coun	try?
	eath v	Funeral	30 Long Beach Ave	nue	Ever in U.S	S.   13. V	11575 Was Decedent of H	lispanic Ori	gin? (Spec		USA 14. Race	- Americ	an Indian,
980	n 72 hours after death with the Maryland "neturel", or items 23e or 28e-f show calcel Ex. offer must be notified at	b	1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2  Armed Forces?  1 Yes 2  Armed Forces?			Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 █️No	Specify:		ican, etc.)		, White,	etc.
5-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra	ducation ade completed)		16a. Deced	dent's Usual Occup kind of work done DO NOT use retired	ation during mos	t of working	9	16b. Kind of Bus	iness/Inc	dustry
121	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		DO NOT use retired tered Nur				Healthc	a <b>r</b> o	
1d 2	filed Hygi Sther	Be Co	17. Father's Name (First, Middle, Last,	1					er's Name (		Maiden Sumame		
ylar		To E	Ernest Fitzgerald	Padmore						dica He			
Maryland 21215-0036	2 2 2		19a. Informant's Name/Relationship ( Eric Padmore/neph				ng Address <i>(Street</i> Bradford				-		
ē,	of Health item 27 other tr	1 3	20a. Method of Disposition		20b. P!	ace of Dispo	sition (Name of matory or other place	1	Da	te :	20c. Location - C		
E C	Pages nent of ant: If it ury or o		1 ☐ Burial 2 XCremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specif				el Cremat		May 200		Odenton,	Mar	cvland
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Lice	lette		1251 B		Hecl	crotte	n Service, P.A.	ce P.O Clarks	. Box	x 784 e, MD 21029
П			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death	. Do not ent	er the mode of dyin	ng, such as	cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Brain Tu								_	
	Examiner			Due to (or as	a consequ	erice or).							
	p ti	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequ	ence of):							
	xecute and II-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequ	ience of);							
68760,	cate be executed physician and the burial-transit			d									
	- 70 -	Medical	IF FEMALE:			10000							
Вох	eath certi attending I for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal	death 3	Ectopic pregnancy	/			23d. Date Mon		ny Day Year
0.	at the de by the a tached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at 9☐ Unknown	time of de	eatn 5∟	Other (specify)						
9	es that igned b	by Pt	Part II. Other significant conditions of	contributing to death b	ut not resu	ılting in the u	nderlying cause giv	en in Part I		23e. Did tob	pacco use contri	bute to th	e cause of death?
Vital Records,	w require been sig should b	ted	Seizure Disorder							1 □ Ye	s 2 X No	3 🗌 Prob	ably 4 Unknown
3ec	elawi hasbu	Completed								24a. Was ar autops perforn	y pr	ere autorior to coreath?	psy findings available appletion of cause of
alF		e Col	25. Was case referred to medical					OC Diese	of Dooth		2 XNo 11	Yes	2□ No
F Vii	ysic is ce direc	To B	examiner?  1  Yes 2  No	Hospital:	ent 2 🗆 I	ER/Outpatier	nt 3 DOA Oth	OC.		e 5 Reside		(Specify	Assisted
n of	ding Ph h. After th funeral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	Wor	k?		3d. Describe ho	w injury occurre	d	
Division	or Attending after death. Director: After in by the fune	icat	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	e One Blace of Inc	uny - At ho	me farm str	M 1 [	Yes 2□	-	If Location (Str	reet and Numbe	r or Rura	I Route Number
Div	al or Attend after death I Director: A d in by the f	Certification:	4 ☐ Homicide determined	building, et	c. (Specify	)	eer, ractory, ontoe			City or Town		0, 1,2,2	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	Medical C	29a. Certifier 1 X Certifying Ph (Checkonly one)	nysician: To the best miner: On the basis of and manner sta	f examinat	wledge, deat ion and/or in	n occurred at the tir vestigation, in my o	ne, date ar pinion, dea	nd place, ar occurred	nd due to the ca d at the time, da	ause(s) and man ate and place, a	ner as st	ated. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	/ /			29c. Licens		210		9d. Date signed	. /	Day, Year)
•			Allei tu	binch	25		Do	05	960-	1	05/06/	105	
			30. Name and address of person who	completed cause of d	teath (Item	23a) (Type,	Print)	thead	, NE	; Wa	os/06/	nD	C 20017
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signat	ture	1	.,	, , ,	,			
	Regist	rar	I WAY TO	ZUUDI	Engles a	FE	A						

			1 - For State Registrar	State of Ma	arylan	d / Depa		lealth an	d Mental Hyg		105	17307
	Dhysia		Decedent's Name (First, Middle, La	•			-		2. Date of Dea Month	th Day	Year	3. Time of Death
	Physic /Medi		Hilario S		Puen	tes			May 4,	2005	rear	4:55 a M
	Examir		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, o	r Location of D	eath	4c. Cour	nty of Death	
			900 Leverton Roa	ıd			Rockvi			Mon	tgome:	ry
	Funeral Director	į.	578-66-9259	ex 7. Ag ⊠M 2□F	e (In yrs. 82	last birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Birth (Month, Day May 22,	Year)	9. Birthp	place (State or Foreign htry) ile
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				1,	0d. Inside City Limits
	Aaryl sho	5	Maryland Mon	<b>.</b>							'	tx⊡Yes 2 □ No
	28e-	ect	10e. Street and Number	tgomery	Ro	ckvill	e 10f. Zip Code	<del>-</del> -		Og. Citizen o	f M/hat Cour	
	With With	<u>Ö</u>	900 Leverton Ro	bed					'		Winat Cour	my r
	death ms 2%	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.	S. 13.	20852 Was Decedent of E	lispanic Origin?	(Specify Yes or No-	USA 14 R	ace - Americ	an Indian
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "neturel", or Items 23a or 28e-f show event. The Medical Examirational be notified at	by Fur	1 ☐ Never Married 21☑ Married 3 ☐ Widowed 4 ☐ Divorced	Amed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:			If Yes, specify Cuba 1-1⊠ Yes 2 □ No		(Specify Yes or No- Jerto Rican, etc.) Chilean	В	lack, White,	etc.
21215-0036	ture FE	edt	15. Decedent's E			16a Dece	dent's Usual Occup	ation		16h Kind of	Business/In	dunte
15	in 72	Completed	(Specify only highest gra	de completed)		(Give	kind of work done DO NOT use retired	during most of	working	16b. Kind of		
72	iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5	5+)		stant Co	,		Kest	aurant	
0	e filed within al Hygiene. ' other then '		17. Father's Name (First, Middle, Last,				Beare co		Name (First, Middle, I	Maiden Suma	ame)	
<u>a</u>	id be ental ked (	To Be	Hilario Puentes					Aur	ora Lagos			
Maryland	2 should be and Mental Is marked o reumatic eve	-	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Address (Street		Rural Route Number	: City or Tow	n. State. Zio	Code)
Ž	nd 2 aith a 27 Is		Olga Maria Munoz	/ Daughter	<u>:</u>	900	Leverto	n Road,	Rockville	. Mar	vland	20852
5	S 1 a item start	1 3	20a. Method of Disposition		20b. P		sition (Name of natory or other place		Date	20c. Location		
9	Page ento		1 □XBurial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif				ven Cemete:	1	ау б, 005 s		<b>G</b> .	
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 is marked eny injury or other treumatic engose.		21. Signature of Funeral Service Licer			T				iiver	Sprin	J, Maryland
ä	Dep time to the control of the contr	b b	Annedian	2//alles		50	ancıs J. O Univer	Collin	s Funeral vd, W, Si]	Home	Inc.	MD 20001
	death certificate be executed  Wedical  Exam  Medical  Figure  And for use as the burial-transit  And for use as the buri	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Respira Due to (or as Pneumon Due to (or as Stroke C. Due to (or as	a consequ ia a consequ	uence of): uence of):	re					Onset and Death
P.O. Box 68	at the death certifica by the attending ph. tached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)				ate of delive	ry Day Year
rds, I	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions of	ontributing to death b	ut not resu	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tob 1 ☐ Ye	32		e cause of death?
Records,	0 - 0	Completed							24a. Was ar autops perform	v	. Were autor prior to cor death?	osy findings available inpletion of cause of
_	iici <b>en:</b> Th certificete ector, pag	e Co	25. Was case referred to medical						1 ☐ Yes 2	No No	1 🗆 Yes	2 No
Vital		o Be	examiner?  1 \sum Yes 2 \overline{\text{N}} No	Hospital:			Othe		Death (Check only on			-
ō		-	27. Manner of Death	i 🔲 inpatre		ER/Outpatien 28b. Time of	1 3 DOA	4   Nursing	g Home 51 Reside			)
	ding l h. After funer	tlon	1 ANatural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	Injury	28c. Injun Worl M 1 □	(? Yes 2 □ No	20d. Describe No	W IIIJuly Occo	11100	
S	r Attending er death. rector: After by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be		ırv - At bo	me farm str			28f. Location (Str	reet and Num	ther or Pum	Pouta Number
2	after Dire	erti	4 Homicide determined	building, etc	(Specify	)	out, ractory, office		City or Town	, State)	Der Or Mura	noute runiber,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical C	(Check only 2 Medical Exan	ysician: To the best of niner: On the basis of	examinat	wledge, death ion and/or inv	occurred at the timestigation, in my op	ne, date and pla pinion, death of	ace, and due to the ca	use(s) and mate and place	anner as st	ated. the cause(s)
	thin (	Med	one)  29b. Signature and title of certifier .	and manner sta	ilea.		29c. License					
	I W L			MK					25	d. Date sign		
	2		1/Nº SAL	1.17				37532		May	4, 20	005
			30. Name and address of person who Praveen K. Gupta				·	ve, Roc	ckville, M	D 2085	2	
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 0 6 200	2. Registra	ar's Signat	ure Span	le					

			1 - For State Registrar		Marylar		artmen rtificat			and M		eg. No.	2009	17308
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle,  Jerry Allen Pife 4a. Facility Name (If not institution, Garrett County I	er give street and num		al		Town, or	Location o	of Death	2. Date of Dear Month May 11,	200 4c. 0	Year 05 County of Dea Garrett	
L	Funeral Director		-		7. Age (In yrs. 63		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day) June 20	Year)	9. Bir Co 941 Wes	thplece (State or Foreign ountry) st Virginia
	he Maryland 8a-f show utified at	ector	10a. State 10b. County WV Tucker	<i>-</i>		ty, Town or Lo								10d. Inside City Limits 1 X Yes 2 ☐ No
	3e or 2	Dir	10e. Street and Number  Rt. 1, Box 18				10f. Zip	287			'		en of What Co USA	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deportment of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or Items 23e or 28e-f show any njury or other treumatic event, I're Modical Exactificational to notified at ance.	by Funeral Director	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deced Armed Ford d 1 Tyes 2 If Yes, Give Year or Dat	es? E <b>∑</b> No		Was Deced If Yes, spec		spanic Ori n, Mexican Specify:	gin? (Spe	ecify Yes or No- Rican, etc.)	ŀ	4. Race - Ame Black, Whit Specify:	
21215-0036	within 72 ho ane. then "natur	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		4or 5+)	(Give life.	dent's Usua kind of wor DO NOT us	rk done a se retired,	luring most )		ng		d of Business	
Maryland 2	uld be filed Mental Hygie rrked other rtic event, II	To Be Co	12 17. Father's Name (First, Middle, L Franklin Bliss			неаvy	7 Equi	<u>.pmer</u>	18. Mothe	r's Name	(First, Middle, I Upton		nstruct Gumame)	.10n
, Mary	and 2 sho salth and I n 27 is me er treums		19a. Informant's Name/Relationshi				ng Address				l Route Number , WV 26	, City or 5287	Town, State, 2	Zip Code)
Baltimore,	Pages 1 ment of He ent: If iten ury or oth		20a. Method of Disposition  1		tate		natory or o	ther place Cemet	ery i	May ]	15,2005	Loc		WV
Balt	permit, Depart Import any nj		21. Signature of Funeral Service L	Jeressa			179 M	ille	st.	, Gr	es, P.A. antsvill	0. 1	O Box 2	275 536
	Pnysician /Medical		23a. Part1. Enter the disease, or of shock, or heart failure. List of immediate Cause (Frinal disease or condition resulting in death)	a. Acute		h. Do not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death immediate
8760,	cate be executed by yesician and the burial-transit	dicai Examiner	Sequentially list conditions, It are a more cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	r as a conseq	uence of	card	liomy	opath	ту				years
O. Box 6	The law requires that the death certific ite has been signed by the attending p page 2 should be detached for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No		th 2 ☐ Feta nt at time of d	Ideath 3	Ectopic pro					23	3d. Date of del Month	ivery Day Year
rds, P.	w requires that been signed b should be deta	ed by Pł	Part II. Other significant condition Rheumatic heart	•		-	, ,		n in Part I.			acco use		the cause of death?
Division of Vital Record											24a. Was ar autops perform 1 \( \text{Yes} \) 2	v !	prior to death?	utopsy findings available completion of cause of 2 No
<u>=</u>	Physiclen: this certificated director,	o Be	25. Was case referred to medical examiner?  1	Hospital: 1	patient 2	ER/Outpatien	at 3 1 00	Othe	PI.		(Check only one		Cother (S-e	-16.1
ion of	Attending Phy of death.  Sector: After this by the funeral of	ation; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of (Month		28b. Time of Injury		8c. Injury Work		2	28d. Describe ho			спу)
Divis	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 286. Place o	f Injury - At ho g, etc. <i>(Specif</i>	ome, farm, str	eet, factory	, office		2	8f. Location (Str City or Town	eet and i	Number or Ru	ıral Route Number,
	To the Hospitel or A within 24 hours after To the Funerel Directompletely filled in by	edical	29a. Certifier 1. Certifying (Check only one) 2 Medical E	Physician: To the base kaminer: On the base and manner	is of examina	wledge, death	n occurred a vestigation,	at the time in my op	e, date and inion, deat	d place, a h occurre	and due to the ca ed at the time, da	use(s) a ite and p	ind manner as place, and due	stated. to the cause(s)
	To the within To the comple	W	29b. Signature and title of certifier	un			29c	. License		333		Od. Date	signed (Mont)	h, Day, Year)
1	Þ		30. Name and address of person we Thomas Johnson,	*	•		•	land,	MD	2155	50			
4X	Sta Registr		31. Date filed (Month, Day, Year)	6 2005 N	gistrar's Signa	ture	Ameralla							

		1 - State of State of Registrar		artment of Health an rtificate of Death		ene g. No.	
Physicia		1. Decedent's Name (First, Middle, Last)  MARGARET LEE GATES	PROKOP		2. Date of Death Month MAY 5, 2	Day Year	3. Time of Death
/Medica Examine		4a. Facility Name (If not institution, give street and num FREDERICK MEMORIAL HOSE	nber)	4b. City, Town, or Location of D		4c. County of Death	
Funeral Director			7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year   If Under 24	Hrs. 8. Date of Birth (Month, Day, YAug - 25,	rear) Cou	place (State or Foreign ntry) ington, DC
r the Maryland r 28e-f show	o.	Usual Residence of Decedent	10c. City, Town or Lo	cation Silver Spring			10d. Inside City Limits 1 ☐ Yes 2 ᡯ No
ath with the h	Director	10e. Street and Number 11800 Eden Road		10f. Zip Code 20904	10g	g. Citizen of What Cou USA	ntry?
036  ours after desail, or items  Eraminer m	by Funeral		2 <b>3</b> No	Was Decedent of Hispanic Origin' f Yes, specify Cuban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ameri Black, White, Specify.Whit	can Indîan, etc.
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours af t Health and Mental Hygiene. item 27 is marked other than "natural", or other traumatic event. It a Madical Exam	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-12)	(Give	lent's Usual Occupation kind of work done during most of DO NOT use retired) Homemaker	working 16	Sb. Kind of Business/Ir	
Maryland 2121 d 2 should be filled within lith and Mental Hygiene. 77 is marked other than " traumatic event. Its Mark	To Be C	17. Father's Name ( <i>First, Middle, Last)</i> Harold Douglas Gates			Name <i>(First, Middle, M</i> a ısta Lee	uiden Sumame)	
Mar and 2 sh ealth and m 27 is m		19a. Informant's Name/Relationship (Type, Print)  Ivan Robert Prokop/ Husb	and 11800	g Address (Street and Number of DEden Road, Si	lver Spring		
Baltimore, Misperial Pages 1 and 2 Department of Health a Important: If item 27 is any injury a other training.	1.0	20a. Method of Disposition  1  Burial 2 □ Cremation 3 □ Removal from S  '4 □ Donation 5 □ Other (Specify)		natory or other place) Ma	ay 10,	c.Location - City or To lver Sprin	
Danit. Depart Import any inj		21. Signature of Funeral Service Consee	50	Ameang Address & Earillyin OO University B	lvd, W, Sil	ver Spring	, Md 20901
Pnysician /Medical		23a. Pan . Enter the disease, or complications that ca shock, or heart allure. List only one cause on ea Immediate Cause (Final disease or condition resulting in death)	nused the death. Do not entrach line.  Solution (1) The solution of the soluti	er the mode of dying, such as care	diac or respiratory arrest	t,	Approximate Interval Between Onset and Death
physicial polysicial physicial cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Price a consequence of):  SLLULITIS  or as a consequence of):	Aureus				
that the death certificate by the attending detached for use as	by Physician/Me	in the past 12 months?	int at time of death 5	Ectopic pregnancy Other (specify)	Ula-	23d. Date of delive Month	ery Day Year
		Part II. Other significant conditions contributing to de				cco use contribute to the	
he law e has b	Completed	NON Q WAVE PERIPHERAL V		DISEASE	performed	prior to co	psy findings available mpletion of cause of 2 No
on or vitaling Physicien  After this certification of the control	Certification: 10 Be	25. Was case referred to medical examiner?  1	patient 2 ER/Outpatient	26. Place of to 3 DOA Cther: 4 Nursin 28c. Injury at Work?  M 1 Yes 2 No	Death (Check only one) g Home 5 Residence 28d. Describe how	be 6 □Other (Specifinity occurred	
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a, Certifying Physician: To the	g, etc. (Specify)	occurred at the time, date and plant	City or Town, S	State)	ntod
To the Ho To the Fu Completely	Medical	(Check only one)    Medical Examiner: On the bar and manner   29b. Signature and title of certifier	sis of examination and/or inv	estigation, in my opinion, death of 29c. License number $\mathcal{D}$ -5777	ccurred at the time, date	and place, and due to  Date signed (Month,	o the cause(s)  Day, Year)
6	1	30. Nam, and address of person who completed cause Lalit Mohan Verma, M.D	of death (Item 23a) (Type, I			MAY 6,	20-3
State Registra			gistrar's Signature				

			For State Registrer	State of	Maryland		irtment of l tificate of		nd Mental	Hygier Reg. 1		ETA Aun		
	Physici /Medic		Decedent's Name (First, Middle, Las Marlene	r) Frances	1	Ritter			2. Date Mont May	of Death	005 005	ear	. Time of Death	0
	Examin		4a. Facility Name (If not institution, give Holy Cross Rehab			er	4b. City, Town, Burtons	sville			4c. County of  Mont	Death Gomes	ry	
	Funeral Director		579-42-9299	ex 7 □M 2031.F	7. Age (In yrs. Ia 70	ast birthday) Yrs.	If Under 1 Year Months Days			th, Day, Ye.	ar)	Country)	(State or Foreign	
0	ef show	tor	Usual Residence of Decedent           10a. State         10b. County           Maryland         Mon	tqomery	10c. City,	, Town or Lo	cation			· · · · ·			Inside City Limits 1 ☐ Yes 2 1 No	_
44	Sa or 284	i Direc	10e. Street and Number 11419 Schuylkill				10f. Zip Code 20852	2		10g.	Citizen of Wha	at Country?	)	Ī
J36	perint. Tages 1 and 2 should be missing within 27 hours and bean manyang perint. Tages 1 and 2 should be manyang inportant: If item 27 la marked other than "netural", or Items 23a or 28e-f show any injury or other traumatic event, the Modical Examination continued an any injury or other traumatic event, the Modical Examination continued and once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Note: Married 2 Married		2 🔼 No	ı		Hispanic Orig pan, Mexican,	in? (Specify Yes , Puerto Rican, et	or No- c.)	14. Race -	White, etc.	ndian,	Ī
21215-0036	ene. than "neture	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-	4or 5+)	(Give life. I	lent's Usual Occu kind of work done OO NOT use retin	during most	of working	16b	. Kind of Busir		ry	
Maryland 2	Aental Hygirked other	To Be Co	17. Father's Name (First, Middle, Last) Vincent Francis		1	11011	emaxel		r's Name (First, M garet Ma:		den Sumame)	JIII C		
, Mary	ealth and Mm 27 la mar		19a. Informant's Name/Relationship (1		OOL DI	3128	Paladi		ror Rural Route I	ney, I	Marylar	d 208	332	X.
altimore,	oartment of H		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service Licen	1)	itate ce	of Hea	sition (Name of natory or other pla ven Cemete Nama and Agdr	ery	ay 9, 2005 Ins Fune:	Sil		ring,	Marylan	ıd
ä	tmpo any ir once		Annedan	etu	ller	50	0 Univer	sity E	Blvd, W,	Silve	er Spri	ng, M	1D 20901	1
	nysician /Medical xaminer	ner	23a. Part1. Enter the disease, or common shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	catic No	on-Sma lence of): 11 Lun	11 Cell g Cancer	Lung C				On 5	erval Between set and Death  Months  Months	
8760,	physician and the burial-transit	dical Examin	Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (d.	or as a consequ	ience of);								
Box 6	e attending	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		rth 2 ☐ Fetal ant at time of de	death 3	Ectopic pregnan Other (specify)	су			23d. Date of Month	,	y Year	
	6 6	d by Pl	Part II. Other significant conditions of Asthma	ontributing to de	ath but not resu	ilting in the u	nderlying cause g	iven in Part I.	23e	Did tobaco			ause of death?  4 □Unknown	
I Rec	ate has b	Complete								Was an autopsy performed Yes 212	? prid	r to comple	findings available etion of cause of No	
Vital	this certificateral director, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	npatient 2 🗆 E	ER/Outpatier	t 3 DOA	thor	of Death (Check		6 ∏Other	(Specify)		-
L .	After After fune	ation: T	27. Manner of Death  1 🖾 Natural 5 🗆 Pending 2 🗀 Accident investigation	28a. Date o (Month		28b. Time of Injury	28c. lnj		28d. Des		njury occurred			
Division	no the nospital of Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place	of Injury - At hou g, etc. (Specify	me, farm, str	eet, factory, office	)		tion (Street or Town, St	t and Number tate)	or Rural Ro	oute Number,	
	ne nospi n 24 hour he Funer cletely fills	edical	29a. Certifier 1 ★ Certifying Ph (Check only one) 2 Medical Exem		sis of examinati					time, date	and place, and	due to the	cause(s)	
)	1	Me	29b. Signature and title of certifier	Sune	elmo	>	D3	se number 85996		29d.	Date signed (I			
_	5		30. Name and address of person who Linda M. Burrel	1, M.D.	2730 t	Univer	sity_Blv	d, #40	00, Wheat	on, N	4D 2090	2		
	Sta Regist		31. Date filed (Month, Day, Year)	005 37 A	egistrar's Signa	" Ap	anti)							

			1 - For State Registrar		aryland /		artment of F				jiene Neg. No.	2005	17311
	Physici	an	Decedent's Name (First, Middle,	Last)						<ol><li>Date of Dea Month</li></ol>	ith Day	Year	3. Time of Death
	/Media	al		mas J. Reit	Z		1 0 T			May	5	2005	10:32 A <sup>M</sup>
1	Examir	er	4a. Facility Name (If not institution, Howard County Ge		+-1		4b. City, Town, o		of Death		4c. Co	ounty of Death Howard	
	Funeral	-		5. Sex 7. Ag	e (In yrs. last i	oirthday,	If Under 1 Year	If Under		8. Date of Birth	3	9 Birthr	place (State or Foreign
	Director		214 01 9125	<b>¼</b> SM 2□F	90	Yrs.	Months Days	Hours	Min.	July 9,	1914	4 Mar	yland
	pu &		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	um or L	cation						lod lasida Cir. Limita
	Aaryla F sho	ō	V										10d. Inside City Limits 1 ☐ Yes 2 No
	the A	rect	MD Howard  10e. Street and Number		Colu	nola	L 10f. Zip Code			-	IOa Citizer	of What Cour	ntry?
	3a or	0	5253 W. Running	Brook #102			21044	4				ted Sta	
	be filed within 72 hours after death with the Maryland ital hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Exaculiser must be notified at	by Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of H If Yes, specify Cuba	lispanic Ori	gin? (Spe	cify Yes or No-		Race - Americ	can Indian,
9	or Ite	y Fu	1 Never Married 2 Marrie	d 1 XYes 2 1	No		1 Yes 2 No	Specify:		nican, etc.)	So	Black, White,	
21215-0036	hours tural',	q p	3 ₩idowed 4 Divorced	Year or Dates:								AALI	ite
7	in 72	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	durina mos.	t of worki	ng	16b. Kind	of Business/In	dustry
2	d with piene. r than	mo	Elementary/Secondary (0-12)	College (1-4or 5	5+)		lity Engi				Baus	sch & L	<b>om</b> b
힏	e filed al Hygid other vent,	Be C	17. Father's Name (First, Middle, La	ist)				18. Mothe	r's Name	(First, Middle, i			
<u>a</u>		To	Robert Reitz				i	Agnes	s Mur	phy			
Maryland	2 8 8		19a. Informant's Name/Relationship				ng Address (Street						Code)
	s 1 and of Health Item 27 other tr		Lawrence Wheeler 20a. Method of Disposition	/Stepson			Robinhood		THE REAL PROPERTY.	-			200
altimore,	Pages nent of I ont: If Its iry or o		1 Burial 2 Cremation 3				sition (Name of matory or other place					ion - City or To	
	글 투운 글 .		* 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lie		M01044		n Natl. (					ngton, '	ly FH Inc.
B	Depa Impo any i		Nem Colli	=- vitte			12 Old Co						
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused by one cause on each li	I the death. Do	not en	er the mode of dyin	g, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pneumon	ia								Onset and Death  2 weeks
8	/Medical Examiner		resulting in death)	Due to (or as	a consequenc	e of):							
Ь	ZAGIIIII.CI	_	Sequentially list conditions,	b. Due to lor as	a consequenc	a of	<del></del>						
	nted Insit	mlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	546 10 101 43	a sone padris								
o,	te be executed ysician and ie burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence	e of):							
3760,		cal		d.									
39	artifica ing ph e as th	Med	IF FEMALE:								201		
Box	death certifica e attending ph d for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal dea		Ectopic pregnancy				23d.	Date of delive	Pry Day Year
o.		ysic	1 Yes 2 No	4☐ Pregnant at 9☐ Unknown	time of death	5 L	Other (specify)						,
٦.	g g g	y Ph	Part II. Other significant condition	s contributing to death b	ut not resulting	in the u	nderlying cause give	en in Part I.		23e. Did tob	oacco use o	contribute to th	ne cause of death?
ecords,	w requires been sign should be	ed by								1 □ Y€	s 2 🗆 N	lo 3 XProb	abiy 4 □Unknown
000	aw rei	Completed								24a. Was a		4b. Were auto	psy findings available
r	0 - 2	E OC								autops perform	ned?	prior to cor death? 1  Yes	npletion of cause of
Vita	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?							(Check only on	e)		
0	hys this al dii	2	1 ☐ Yes 2⁄2 No	Hospital:			t 3 DOA Othe	er: 4 □ Nu		ne 5 🗆 Reside			/)
	ling After	tion	27. Manner of Death  1. Natural 5 Pending 2 Accident investigat	28a. Date of Injui (Month, Day	Year) 285.	Time o Injury	Worl	/at ⟨? Yes 2.∐i		8d. Describe ho	w injury oc	ccurred	
Division	Il or Attending after death. Director: After d in by the fune	fica	3 ☐ Suicide 6 ☐ Could no	be 28e. Place of Inju	ury - At home,	farm, sti	eet, factory, office	,03 2	-	8f. Location (St.	reet and Ni	umber or Rura	I Route Number.
S	al or safter	Certification:	4  Homicide determine	building, etc	c. (Specify)					City or Town			
	he Hospital or in 24 hours affe he Funeral Dir. pletely filled in I	edical	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best of the basis of and manner sta	examination a	ge, deat nd/or in	n occurred at the tim vestigation, in my or	ne, date and pinion, deat	d place, a th occurre	and due to the ca	ause(s) and ate and pla	manner as st ce, and due to	ated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	0			29c. License	number		25	9d. Date sig	gned (Month, I	Day, Year)
			Hary Trac	la MD			D2258	37			May	5, 200	5
)0	2		30. Name and address of person wt Gary Prada, MD	completed cause of di 11055 Litt				7 Co]	Lumbi	a, MD	21044		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature								
DU	MH 17 Rev 1/20		MAY 1 0	2005	me de	1	DENEL STREET						

			For State Registrar	1 1040	State of		d / Depa		t of H	lealth a			giene 2	005	17312
	9		Decedent's Name (	(First, Middle, L	ast)						-	2. Date of De	ath		3. Time of Death
	Physici		JAMES	c.	ROBINSON							MAY 6	2005	Year	8:50 P M
	/Medic Examin		4a. Facility Name (If n	ot institution, g	ive street and numb	er)		4b. City,	Town, or	Location of	of Death		4c. Cou	inty of Death	
			HOLY CROS	S HOSP	ITAL			SIL	VER	SPRIN	<b>IG</b>		MON	TGOMER	Y
	Funeral		5. Social Security Nur		Sex 7. 1 2X M 2 □ F	Age (In yrs.		If Under Months	1 Year Days	If Under	Min.	8. Date of Birt (Month, Da	h /, Year)	9. Birthp	olace (State or Foreign
	Director		249-44-402		122 M 20 F	72	Yrs.					July 17	1932	South	Carolina
	and		Usual Residence of D 10a. State	10b. County		10c. City	y, Town or Lo	cation						1	10d. Inside City Limits
	Mary f sho	jo	MD	Prince	George's	Т	andove	r							1 X Yes 2 ☐ No
	1 the	Director	10e. Street and Numb		ccorge 5			10f. Zip	Code				10g. Citizen	of What Cour	ntry?
	72 hours after death with the Maryland natural, or items 23a or 28a-f show disal Examinar musi be nuiffed at	O E	7934 She	riff Ro	oad				2078	5			U.S.A		
	deatl	Funeral	11. Marital Status		12. Was Decede		S. 13.	Was Deced	lent of Hi	ispanic Orig	gin? (Spe	cify Yes or No Rican, etc.)	14. [	Race - Americ	
9	after or ite		1 Never Married	2 Married		□ No	į	1 ☐ Yes		Specify:	i, rueito i	nican, etc.)	1	Black, White, ecify: <b>U</b> •	S.A.
ဗ္ဗ	72 hours 'natural', dical Exa	d by	3 Widowed 4	Divorced	Year or Date	es:							Зре	scriy.	
5	x 32	Completed		<ol><li>Decedent's only highest g</li></ol>	Education grade completed)		16a. Dece (Give	kind of wor	rk done d	during most	t of workii	ng	16b. Kind o	f Business/In	dustry
12	within ene. than *	dw	Elementary/Second	dary (0-12)	College (1-4	or 5+)		DO NOT us					C	<b>-</b>	
d 2	be filed within tal Hygiene. d other than avant, the Ma	e Co	12th 17. Father's Name (F)	irst, Middle, La	st)		L PO.	lice (	)1116		r's Name	(First, Middle,		nment	
an	D 00 00	<b>m</b>	Coley E	Robins										,	
Maryland 21215-0036	2 should land Menl is marked	2	19a. Informant's Nam				19b. Mailir	ng Address	(Street a			Cantey Route Number		wn, State, Zip	Code)
	C		Ida Rob	inson/W	life		+	•				ver, Ma			
<u>6</u>	s 1 and 2 of Health item 27 other tra		20a. Method of Dispo	sition		1 ^	lace of Dispo emetery, crei	sition (Nan	ne of			ate	_	on - City or To	own, State
Ë	Pages nent of I int: If it		1 🔀 Burial 2 🗌 `4 □ Donation 5		☐Removal from St cify)	ate	arvlan	•		' '_	/13/	05	Che1te	enham,N	Maryland
Baltimore,	arth orts inju		21. Signature of Fun	nal Service Lig	ansao							B. Jenl			
m	Dep Imp		(X)	QM/	$\rightarrow$		2	7474	Land	over	Road	Landov	er,Man	ryland	20785
			23a. Part1. Enter the shock, or heart	disease, or co	mplications that cau ly one cause on eac	sed the death	h. Do not ent	er the mod	e of dyln	g, such as	cardiac o	r respiratory ar	rest,	20	Approximate Interval Between
	Physician		Immediate Cause (Fi	inal	Met	astic	Prosta	te Ca	rcin	noma					Onset and Death
	/Medical Examiner		resulting in death)		Due to (or	as a consequence Ren	uence of):								
	LAdimine	_	Sequentially list cond	ditions,	b			Ture							
	ed sit	ine	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in	nediate ying iury		as a consequence of sis	uence or):								
•	be executed sician and burial-transit	Examiner	that initiated events resulting in death) La	_	C	as a consequ	uence of):								
760,	te be ex tysician ne buria	caiE		· ·	© d										
89	ificate g phys as the	ed			ч.								- 5.4		
Вох	death certificat e attending phy d for use as th	M/M	IF FEMALE: 23b. Was decedent p	oregnant ,	23c. If yes, outco	me of pregna		Dectopic pr					23d.	Date of delive	ery
	0 0 0	sicia	in the past 12 m 1 ☐ Yes 2 ☐ I			nt at time of de		Other (sp						Month	Day Year
P.0	requires that the de een signed by the a nould be detached	Physician/M	9 Unknown		rand Walted										
ŝ	res tha igned be det	b	Part II. Other signific	ant conditions	contributing to dea	th but not resi	ulting in the u	nderlying c	ause give	en in Part I.					he cause of death?
Record	w requir been si should	ompleted										1 1 1	es 2 No	3 Proc	ably 4 Unknown
ec	aw Is b	nple										24a. Was autop	sy	prior to cor	psy findings available mpletion of cause of
		Cor										perfo		death? 1 ☐ Yes	2 No
Vital	Physician: T this certificat ral director, pa	Be	25. Was case referre examiner?		Hospital:				Othe			(Check only o			
o		5	1 ☐ Yes 2 🛣 No.	0	28a. Date of		ER/Outpatier 28b. Time o		8c. Injury	4 🗆 140		ne 5 🗆 Resid			(y)
o	ding h. After funer	tion	1 XNatural 2 ☐ Accident	5 Pending investigat	(Month,	Day Year)	Injury	м	Work				,,		
Division	l or Attanding after death. Diractor: After I in by the fune	ertification;	3 Suicide	6 Could not	be 28e. Place of	Injury - At ho	ome, farm, str	eet, factory	, office		2			ımber or Rura	al Route Number,
á		Cert	4  Homicide		building	, etc. (Specify	V)					City or Tox	n, State)		
	Hospital 24 hours a Funeral I		29a. Certifier 1 (Check only 2	Certifying	Physician: To the b aminer: On the bas	est of my kno	wiedge, deat	h occurred	at the tim	ne, date an	d place, a	nd due to the	ause(s) and	manner as si	tated.
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	ledicai	one)		and manne		tion and/or in				th occurre		·····		
	To To To to to	Σ	29b. Signature and til	tie of certifier	0 0-			290	. License	a number			29d. Date siç	ned (Month,	uay, Year)
^	10		· mu	100	hula				0062	2520			May	7, 20	005
R	15/		30. Name and address												
	Sta	rte.	31. Date filed (Month,	, Day, Year)	a M.D. 1	vintendo Cinno	ALLEO A		Road	l Silv	ver S	Spring,	Md 20	910	
	Registr			1 1 0 20	05	pistrar's Signa	400	de							

			For Stata Registrar	State of Ma	-	epartmer C <i>ertificat</i>			and M	lental Hy	giene Reg. No.	2005	17319
	Physici		Decedent's Name (First, Middle,     MARGARET LOUIS	,						2. Date of De Month		Year	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution,			4b. City,	Town, or	r Location o	f Death	11/44		county of Deatl	h
	LAdiiii	ICI	WASHINGTON COUNT				HAG	ERSTO	WN			WASHIN	
	Funeral			i. Sex 7. Age	(In yrs. last birth	day) If Unde	r 1 Year	If Under 2		8. Date of Bir (Month, Da	th v Year		hplace (State or Foreign untry)
	Director		219-20-0640	1□M 2XIF	83 Y	rs.	Days	nouis	IVIII I.	DEC. 1	<b>,</b> 192	1 MÃ	RYLAND
	and **		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
	Manyl f sho	0	MARYLAND WASHII	VICTONI	,,		NSBO	DΩ					1X Yes 2 No
	28a-	Director	10e. Street and Number	NGTOIN			Code	KU .			10g. Citize	on of What Co	untry?
	3a or	0	11 SCHOOLHOUSE (	COURT				21713				U.S.A	1
	deat	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.S.	13. Was Dece	dent of H	ispanic Orio	gin? (Spe	ecify Yes or No Rican, etc.)	)- 14	Race - Amer Black, White	ncan Indian,
92	hours after death with the Maryland turel, or Items 23a or 28a-f show at Examinat must be notified at	E	1 Never Married 2 Married		0	1 ☐ Yes		Specify:	, - 46110	nicali, etc.)		Specify:	
Ö	hours turel;	d by	3 ☐ Widowed 4 ☒ Divorced	Year or Dates:	160 5								WHITE
15	in 72	lete	15. Decedent's (Specify only highest	grade completed)		ecedent's Usu Give kind of wo life. DO NOT u	ork done o	during most	of worki	ng	16b. Kind	d of Business/I	ndustry
212	d within 72 hours after death with the Marylan jiene. rthan "naturel", or Items 23a or 28a-f show Ite Madeal Examinat must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)		ERK	,			DEPA	ARTMENT	STORE
פַ	Hyge Hyge	BeC	17. Father's Name (First, Middle, La	ist)				18. Mothe	r's Name	(First, Middle			. 51010
Maryland 21215-0036	should be and Mental s marked c umetic eve	70 E	CHARLES D. SMITH	ł				MART	на Е	LLEN L	POLE		
lar	and and is m		19a. Informant's Name/Relationship			Mailing Address							
	l and i		RONALD E. REEDEI	R/SON		6 WINDI		AK DR		-			
Baltimore,	e = 5 o = 5		20a. Method of Disposition 1 ☑Bural 2 ☐ Cremation 3		20b. Place of E cemetery,	crematory or o	me or other plac	· 1		ate		ation - City or	
Ħ	it. Pa rtmer rtant: njury		' 4 ☐ Conation 5 ☐ Other (Spe 21. Sign ture of Fu A al Service Ma	Z 1	BOONSB	ORO CEM 22. Name ar				/2005			MARYLAND
Ba	permit. Departr Importa any nji				M. Dean	BAST B				Boonsb		tional	
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused	the death. Do no	t enter the mod	de of dyin	g, such as	cardiac c			naryrai	Approximate
	Pnysician		Immediate Cause (Final	(1	tra cra		He	1.00	2.0	7. 4			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		consequence of		No	Choca	- Vac				2- ( 1114"
	Examiner		Sequentially list conditions.	b. Hy	nectous	in							LEADLE
	od sit	iner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of	):	1 Fiam	MERS		1. 1. 2			V 0 0
	and and I-tran	Examin	that initiated events resulting in death) Last	C	And CLCD accounts of		LAEI	MENS		0186713	Ŀ		YEARL.
8760,	cate be executed physician and the burial-transit				. 30/130423/100 0/	,•							
687	death certificate be executed e attending physician and of for use as the burial-transit	edical		d.						_			
Вох	leath certific attending p I for use as:	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		- ==					23	d. Date of deli-	very
_	ne death the atte hed for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 4 Pregnant at 1		3 □Ectopic p 5 □ Other (sp						Month	Day Year
<u>О</u>	that the ded by the detached	Physician/M	9 □ Unknown	9□ Unknown									
	es ign	by	Part II. Other significant conditions	s contributing to death bu	t not resulting in t	he underlying o	ause give	en in Part I.					the cause of death?
orc	v requir been s should	eted								10	Yes 2 🗆	No 3□Pro	bably 4/SUnknown
Records,	a sc	ompleted								24a. Was	an osy ormed?	24b. Were aut prior to c death?	topsy findings available completion of cause of
alE	Th ate pag	O								1 Yes	2 2 No	1 Yes	2 No
Vital		o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 Anpatier	a∏ED/0	atient 3 d	Othe	20		(Check only o		7eu (e	w. i
of	Phys er this	$\vdash$	27. Magner of Death	28a. Date of Injury (Month, Day		ne of 2	28c. Injury	/ at		ne 5 🗌 Resi 28d. Describe I			ıfy)
ion	Attending r death. actor: After by the fune	ation	1 2 Natural 5 ☐ Pending 2 ☐ Accident investigat		Year) Inj	ury M	Worl	<br Yes 2 □ N	No				
Division of	er der racto by th	ertification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		ry - At home, farm	street, factor	y, office		2	28f. Location (S		Number or Rui	ral Route Number,
ā	itel or irs afte rel Dira led in l	Cer							1/2				
	To the Hospitel or Attending Is within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of caminer: On the basis of	examination and/	death occurred or investigation	at the time, in my or	ne, date and pinion, deat	d place, a h occurre	and due to the ed at the time,	cause(s) ar date and p	nd manner as lace, and due	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stat	ed.	290	c. License	number			29d. Date :	signed (Month	Day, Year)
)	⊢ ≯ ⊢ ŏ		Mn.	, Mr	)		7	1665	61		Mais	8/2	2005
			30. Name and address of person with	To completed cause of de	eath (Item 23a) (T	ype, Print)	0	TUSI	<i>U</i> /		ring	0(7)	1 2003
0	4-5		Gimma Qu	DIR 1190 M	T MOTORA	(lom)	H	MG IN	10cm	1 mD	217	40.	
	Sta		31. Date filed (Month Day Year)	2005 32. Pegistra	r's Signature	Angell.	,	-					
	Registr	ar		1 There	- 1	La land							

State

Registrar DHMH 17 Rev 1/2001

		_	For State Registrar	State of	Marylan		artment <i>tificate</i>			nd Me	ental Hy	ygie Reg.	6. 0	05	17:	314
ľ	Physicia	an	1. Decedent's Name (First, Middle, Last)								2. Date of D Month		Day	Year	3. Time of	
	/Medic	al	ROGER LEE RUFF  4a. Facility Name (If not institution, give s	treet and numb	ner)		4h City 1	Town, or Le	ocation of		MAY 1	12,	2005 4c. County	of Death	3:13	РМ
	Examin	er	GARRETT COUNTY MEM			L		KLAND					GARRE			
	Funeral Director		5. Social Security Number 6. Sex 1 220–48–7794	7 M 2□F	. Age <i>(In yr</i> s. 55	last birthday) Yrs.	If Under Months		f Under 2 Hours	Min	B. Date of B (Month, D JUNE	Dav. Ye	ar) 1949	9. Birthp Cour MD	ilace (State or ntry)	r Foreign
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							1	0d. Inside Cit	y Limits
	Maryla -f sho	ţō	MD GARRETT			0.	AKLAN	D							1 📉 Yes	2 🗌 No
	th the	lirec	10e. Street and Number				10f. Zip	Code				10g.	Citizen of W	hat Cour	ntry?	
	death with the Maryland rms 23a or 28e-f show r roust be rediffed at	raic	530 W. LIBERTY STR			2 40 1	215			:-0 /0			USA	- Amaria	an Indian,	
05	be filed within 72 hours after death with the Marylan Hygiene. d other then "natural", or items 23a or 28e-f show evant, the Medical Exercities must be notified at evant, the Medical Exercities in the modified at	by Funeral Directo	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 [※Divorced	12. Was Deced Armed Ford 1 X Yes 2 If Yes, Give Year or Dat	es? !⊟NoVTI	ET-	was Deced fYes, spec 1 ☐ Yes 2	fy Cuban,	Mexican, Specify:	In? (Spec Puerto R	ify Yes or N ican, etc.)	10-		k, White,		
3	2 hou		15, Decedent's Edu (Specify only highest grade	cation		16a. Deced	dent's Usua kind of wor	l Occupati	on ring most	of workin	a	161	, Kind of Bu	siness/In	dustry	
N	within 7 iene. then "n	Completed	Elementary/Secondary (0-12)	College (1-4	4or 5+)	life. I	DO NOT us	e retired)	ing most	or woman	y		ADTO 6	7 M A M 7		
ч	filed w Hygier Sthar ti		17. Father's Name (First, Middle, Last)			R021	NESSM		8. Mother	's Name	(First, Middl		ADIO S		LON	
and	id be i ental l ked o ic eva	To Be	UNKNOWN						EDNA	A ERN	ESTIN	ЕН	INEBAU	JGH		
ary	s 1 and 2 should be f Health and Mental item 27 le marked other traumatic ev	-	19a. Informant's Name/Relationship (Ty			19b. Mailir	ng Address	(Street an	d Number	r or Rural	Route Num	ber, C	ty or Town,	State, Zip	Code)	
Σ	s 1 and 2 of Health a itam 27 la other tra		JOHNATHAN RUFF - S	ON	205 (	_	OTHIA			L		-	, MD 2			
ore ore	Pages 1 ent of H int: If ital		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F	emoval from S	(atter	Place of Dispo cemetery, cren KLAND				5/18,				•	ARYLAN	D
		1	*4 ☐ Donation 5 ☐ Other (Specify)  21. Signatur of Fine   Service License	90	UA		. Name an					-	OX 243		AKI LAN	D
a T	permit. Departr Import		the wil MLU	unt	M001	167 I	URST	FUNE	RAL H	HOME			D, MD		0	
	Physician	: 14	23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on ea	ch line.	h. Do not ent									Approximate Interval Bety Onset and D YEARS	ween
	/Medical Examiner		resulting in death)  Sequentially list conditions,	)	r as a consec											
Ö,	yate be executed obysician and the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	s	r as a consec											
98/60	ficate b physic s the b	edical	<b>N</b> .	d												
C. Box	the death certificate the attending phys ched for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Feta nt at time of o	aldeath 3□	Ectopic pro						23d. Date Mor			/ear
7	law requires that the de as been signed by the a 2 should be detached t	ρχ	Part II. Other significant conditions con	ntributing to dea	ath but not res	sulting in the u	nderlying ca	ause given	in Part I.						he cause of do pably 4 □U	
Records,	The te h	Completed							<del></del>		24a. Wa aut per 1 \( \text{Yes}	opsy formed	1?	Vere auto rior to co leath?	ppsy findings a mpletion of ca 2 \square No	available ause of
Vital R	Physician: Th r this certificate ral director, pac	Be C	25. Was case referred to medical examiner?	de enited:							(Check only					
	Physion this contained in the contained	2	1 ☐ Yes 2 🛣 No			ER/Outpatier 28b. Time o		A Other: 8c. Injury a	4 🗀 1401				e 6 ⊟Othe		y)	
0	e e e	tlon	1 ØNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of (Month	, Day Year)	Injury	м	Work?	s 2 🗆 1				. ,			
Division of	i Pite	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building	of Injury - At h g, etc. (Speci	ome, farm, str fy)	reet, factory	, office		2	8f. Location City or T	(Stree	t and Numbe itate)	er or Rura	al Route Num	ber,
	To the Hospitel Within 24 hours of To the Funerel completely filled	edical (	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medicel Exemi	sicien: To the I ner: On the ba and mann	sis of examin	owledge, deat ation and/or in	h occurred vestigation,	at the time in my opir	, date and nion, deat	d place, a th occurre	nd due to th d at the time	e caus e, date	e(s) and ma and place, a	nner as s and due to	tated. o the cause(s	)
	To the To the comp	ž	29b. Signature and title of certifier					License					Date signed			
			1 Danit	ne	-			H2615	4	-		l I	1AY 13	, 20	U	
10	AV+		P. DANIEL MILLER,	D.O.	69	WOLF A		DRIV	E	OAKL	AND,	MD	21550			
	Sta Registi		31. Date filed (Month, Day, Year)  MAY 1 6		gi <b>s</b> trar's Sign	ature	Cook									

		_	1 - State Registrar	artment of Health and Months	Re	g. No.	17318
	Physicia	e an	Decedent's Name (First, Middle, Last)		<ol><li>Date of Death Month</li></ol>	Day Year	3. Time of Death
	/Medic			Jr.	May 8	, 2005	11:57A M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death Frederick	_
			Frederick Memorial Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Frederick  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth		
	Funeral		048-05-5812 1 M 2 XF 85 Yrs.	Months Days Hours Min.	(Month, Day, Aug. 22	, 1919 Conn	ace (State or Foreign try) ecticut
	Director		Usual Residence of Decedent		1145. 22	, 1313 3311	
	yland now	Ì	10a. State 10b. County 10c. City, Town or L			11	Od. Inside City Limits
	Mar-fall	5	Maryland Washington Hager	stown			1 Yes 2 No
	or 28	ire	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Coun	
	23a (23a)	al	17221 Amber Drive	21740		United Sta	
	r dea	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	within 72 hours after death with the Maryland ene. than "naturef" or items 23a or 28a-f show the Jical Exirciper must be collified at	by Ft	1 Never Married 2 Married 1 Myes 2 No World	1 ☐ Yes 2 X No Specify:		Specity: LTb	ite
21215-0036	hours	q p	3 □ Widowed 4 12 Divorced Year or Dates: War II  15. Decedent's Education   16a. Dec	edent's Usual Occupation		16b. Kind of Business/Ind	
7	n 72	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of workir DO NOT use retired)	ng	TOD. THE OF BUSINESSAME	1430 y
12	withi ene. than	шc	Elementary/Secondary (0-12)   College (1-4or 5+)	untant	ŀ	US Governme	nt
0	filled Hygi other ent, I	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, M	Maiden Surname)	
<u>a</u>	should be filed within 72 hours after death with the Marylan nd Mental Hyglene. marked other than "natural", or items 23a or 28a-f show maric event, it a Medical Extending at matter or colling at	To B	Dr. John Leo Renehan, Sr.	Marie So	chanberg	er	
Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es ance.			ling Address (Street and Number or Rura.  Lookout Lane, Fred			Code)
ē,	Healt Healt tem 2					20c. Location - City or To	wn, State
Baltimore,	Pages ent of ht: If i		INCENTIAL 2 Cremation 3 Desiroval from State	n Mem. Garden 5/12	/2005	Frederick,	Maryland
薑	ariti. Partimontari					Funeral Hom	
m	Depar Impor any ir		Mustney Staulter	1621 Opossumtown Pi	ike, Fre	derick, MD	21702
			23a. Pan1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or	r respiratory arre	est,	Approximate Interval Between
	Pnysician :		Immediate Cause (Final disease or condition	ne lunes			Onset and Death
	/Medical-		Immediate Cause (Final disease or condition resulting in death)  a	f			
н	Examiner						
	<b>n</b> .≅	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. Due to (or as a consequence of):				
	acute ind trans	Examin	that initiated events c.				
90,	death certificate be executed e attending physician and of for use as the burial-transit	ũ	resulting in death) Last Due to (or as a consequence of):				
8760,	cate b	dical	d				
x 6	leath certifica attending phy I for use as th	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	inv
Вох	atten for us	Physician/M	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
o.	at the de by the a	ysic	1 U Yes 2 No 9 Unknown				
Д	that the ed by detain		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	pacco use contribute to th	e cause of death?
ds	uires signa Id be	d by	hypoalbiemi nemia		1 🗆 Ye	s 2 No 3 Prob	abiy 4 Sunknown
S	w requ	iete	Chronic renal failure		24a. Was ar		psy findings available
Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed	//		autops	ned?   death?	npletion of cause of
e		e Co	25. Was case referred to medical	26. Place of Death			2 No
Vital		o Be	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient	Othor		ince 6 ☐Other (Specifi	/)
of	Phys er this eral di	-	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 2		w injury occurred	,
on	nding Fith. The After a funera	atio	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	M 1 Yes 2 No			
Division	or Attending after death. Director: After d in by the fune	ifice	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Sti	reet and Number or Rura	l Route Number,
Ö	_ 0	Certification;	Dullying, etc. (Specify)		0.1,		200
-	ospit hour unera ly fille		29a. Certifier (Check only (Ch				
Y	To the Hospital o within 24 hours aft or the Funeral Di completely filled in	Medicai	one) and manner stated.				
	To To COUT	2	29b. Signature and title of certifier  MD	29c. License number		9d. Date signed (Month,	uay, redij
•	X		t-p	MDD0054636	1	May 9, 2005	
	3		30. Name and address of person who completed cause of death (Item 23a) (Type		1701		
				e., Frederick, MD 2	1/01		
*	Sta Regist		31. Date filed (Month Day Year) 1 2005	(Specific			
	riegist	5 . in		*			

			For State PAN, ST. MAI	<sup>33a</sup> State of I	Maryland / D -05		rtment of Herificate of L		l Mental Hy	giene Reg. No	/ 1115	17316
		8	Decedent's Name (First, Middle, and a second s						2. Date of D			3. Time of Death
	Physici /Medic		SHERMAN LE		BBINS				MAY	8	2005	8:07 A M
	Examin	er	4a. Facility Name (If not institution, g 16940 TEAGUES F		er)		4b. City, Town, or HUGHESV		ath	40	. County of Death CHARLES	
	Funeral			. Sex 7.	Age (In yrs. last birti	hday)_	If Under 1 Year   Months Days	If Under 24 H		rth	9. Birthi	place (State or Foreign
	Director		176-32-7518 Usual Residence of Decedent	1(XM 2□F	67	rs.	Days	1100.0	FEB. 3	, 193		NŚYLVANIA
	yland		10a. State 10b. County		10c. City, Town	or Loc	ation					10d. Inside City Limits
	r 28a-f show	Director	MD CHARLES		HUGHE	SVI						1 ☐ Yes 2,☐ No
	death with the Maryland ms 23a or 28a-f show roust be notified at	Dire	10e. Street and Number 16940 TEAGUES I	OTNT ROAD			10f. Zip Code 20637			-	lîzen of What Cou	ntry?
	death w	Funerai	11. Marital Status	12. Was Decede		13. W	as Decedent of His Yes, specify Cubar	spanic Origin?	(Specify Yes or N		14. Race - Ameri Black, White,	
36	hours after death with tural; or Itams 23a or al Exament ust be.	by Fu	1 ☐ Never Married 2점 Married 3 ☐ Widowed 4 ☐ Divorced	1 1X Yes 2			Tes, specify cubar	Specify:	ento rilcan, etc.)		Specify:	
21215-0036			15. Decedent's	Education		Decede	ent's Usual Occupa	tion		16b. K	WH.	
21	within 7 ene. than "n	Completed	(Specify only highest : Elementary/Secondary (0-12)	College (1-4	or 5+)	life. De	O NOT use retired)		vorking			
	filed w Hygier other ti	e Co	12 17. Father's Name (First, Middle, La	st)		ONC	RETE FINI	18. Mother's N	lame (First, Middle		NSTRUCTIO Surname)	ON
/an	2 should be filed withir and Mental Hygiene. Ie markad other than aumatic evant, Ite M.	To B	GUY WALTER ROE	BBINS				MART	HA KATE RA	ADABA	AUGH	
Maryland	2 sho and h ie ma rauma		19a. Informant's Name/Relationship				Address (Street a					
e, l	s 1 and 2 should be filed within 72 hr Health and Mental Hygiene. Item 27 ie markad other than "natu othar traumatic evant, Itta Madical	0.400	BARBARA L. ROBBI  20a. Method of Disposition	NS / WIFE	20b. Place of	940 Disposi	TEAGUES tion (Name of story or other place	POINT	Date		LLE MD 2 ocation - City or To	
D III	Pages nent of int: if i	- [	¹2⊠Burial 2 ☐ Cremation 3 ¹ 4 ☐ Donation 5 ☐ Other (Spe				cH.CEMET			BRYA	ANTOWN, N	1ARYLAND
Baltimore,	permit. Pages 1 and Department of Health important: if itam 27 any injury or other tonce.		21. Signature of Funeral Service Lice	ensee		22.	Name and Address	s of FacilityBI	RINSFIELD	-ЕСН	OLS FUNL	HME.,P.A. MD 20622
	11		23a. Part1. Enter the disease, or co shock, or heart failure. List or	emplications that cau by one cause on eac	sed the death. Do n h line.	ot enter	the mode of dying	, such as card	iac or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Me	tastatic	. 0	sopha	Seal	canco	1		months
	Examiner			Due to (or	as a consequence of	of):	W					
	p ii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events	Due to (or	as a consequence of	of):						-
	xecute n and al-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequence of	of):		_				
68760,	icate be executed physicien and s the burial-transit	dicai		d								
x 68		w w	IF FEMALE:	00- 16					-	1	- 1	
Box	leath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?		1 2 Fetal death t at time of death		Ectopic pregnancy Other (specify)				23d. Date of delive Month	ery Day Year
P.O.	that the de ed by the detached	hysi	9 Unknown	9□ Unknow	n							
Records, F	w requires that the death certif been signed by the attending should be detached for use a	by	Part II. Other significant condition	s contributing to deat	h but not resulting in	the uno	derlying cause give	n in Part I.	23e. Did	_	use contribute to t	he cause of death? pably 4 □Unknown
Seco	> 0 70	Completed							24a. Was	psy	24b. Were auto prior to co death?	ppsy findings available impletion of cause of
_	ician: The lav certificate has ector, page 2	e Cor	25 Man gaza referred to modical					00 81	1 ☐ Yes	ormed? 2) No		2 🗆 No
Vital		0 B	25. Was case referred to medical examiner?	Hospital:	atient 2 ER/Out	patient	3□ DOA Othe		Home 5		6 ☐Other (Specif	(y)
		on: T	27. Manner of Death Natural 5 Pending	28a. Date of I (Month,		îme of njury	28c. Injury Work		28d. Describe	how inju	ry occurred	
Division	Attano r death ector: by the	Certification:	2 Accident investigat 3 Suicide 6 Could no 4 Homicide determin	be 28e. Place of	Injury - At home, far etc. (Specify)	m, stree		es 2 No	28f. Location City or To		nd Number or Rura	al Route Number,
	pital or urs afte aral Dir illed in		On Cartifica Contifuin			d- ast-			<u> </u>			
	e Hospital 124 hours a e Funeral letely filled	Medical	29a. Certifier Certifying (Check only one)	Physician: To the be aminer: On the basi and manner	s of examination and	dorinve	estigation, in my op	e, date and pla inion, death oc	ce, and due to the curred at the time	date and	) and manner as s d place, and due to	tated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	0602	A		29c. License	number		29d. Da	te signed (Month,	Day, Year)
			Plato	1/200	A door to the same	Tues - S	U50	100		5	14/05	2
_			30. Name and address of person w	itel.	MD 110			DAD SUI	TE 212 P	RINC	E FREDER	ICK,MD20678
	Sta Registi		31. Date filed (Month, Day, Year)  MAY 1		istrar's Signature	4	neck					

				State of N	Maryland / Dep			•	_	e.
		•	1 - For State Registrar			ertificate of			Reg. No.	0 1/3//
			1. Decedent's Name (First, Middle	, Last)				2. Date of Dea Month		3. Time of Death
	Physici /Medic		Lucila Ram	os				May	6 200	
	Examin		4a. Facility Name (If not institution	, give street and number	r)	4b. City, Town,	or Location of Death		4c. County of	Death
			Shady Grove Ad			Rockv:			Montg	
	Funeral Director		5. Social Security Number 578–21–2047	6. Sex 7. A 1 □ M 2 🛣 F	Age (In yrs. last birthda 88 Yrs.	Months Days		8. Date of Birtl (Month, Day May 5,	, Year) 9 1917 ]	Birthplace (State or Foreign Country) Peru
	pu 🖈		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Maryla I shov	tor	,	gomery		ersburg				1X Yes 2 No
	r 28g	Irec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
	th wit	aiD	17 E. Deer Pa	rk Drive		20	877		Peru	
	dea	ner	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S. 13 s?	. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No-	14. Race - Black.	American Indian, White, etc.
36	irs after	by Funeral Director	1 ☐ Never Married 2 🔀 Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	0 No	1 X Yes 2□ No			Specify:	White
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The Montant: If Item 27 is marked other than "natural", or items 23a or 28a-f show sny injury or other traumatic evant, The Modical Examinar must be notified at once.	Completed	15. Deceden (Specify only highes	's Education it grade completed)	16a. Dec	edent's Usual Occu	pation during most of work	ring	16b. Kind of Busin	ness/Industry
12	withir ane. than	щ	Elementary/Secondary (0-12)	College (1-40	r 5+)	nemaker	,,,		Own Hom	P
d 2	filed Hygi other	ပိ	17. Father's Name (First, Middle,	Last)	nor	пещинет	18. Mother's Nam	e (First, Middle,	Maiden Sumame)	<u> </u>
an	d be ental kad c	To Be	Dionicio Gam	ooa			Patro	cinia Ot	iniano	
<b>lary</b>	i 2 should be filed within 7 n and Mental Hygiene. 7 is markad othar than "r raumatic evant, the Med	-	19a. Informant's Name/Relations							antown, MD
e)	1 and 1ealth am 27 thar t		Rosa L. Wenze	L / Daugnte				Date	20c. Location - Cit	
Baltimore,	Segues := 150 /O		1 X Burial 2 Cremation	3 Removal from Sta	10	position (Name of rematory or other pla	1	11,		wn, Maryland
Ë	it. Partment		* 4 □ Donation 5 □ Other (S		!	ls Cemete	ry   200.			wii, Haryrana
Ba	Depar Impo any ir		) for C.	WL			Park Dr.			MD 20877
I	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition		ed the death. Do not end in line.		ing, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death Minutes
	/Medical		resulting in death)		as a consequence of):					
8	Examiner		Sequentially list conditions	b. Conges	tive Heart	Failure				Days
	led Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Emer underlying Cause (Disease or injury that initiated events		as a consequence of):					Years
Ć,	execuin and ial-trai	Exar	that initiated events resulting in death) Last		Failure as a consequence of):					Icars
8760,	certificate be executed ding physician and use as the burial-transit	cai		d. Atrial	Fibrillat	ion				Years
.O. Box 68	atter for u	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown		2 Fetal death 3 at time of death 5	B Ectopic pregnand Cother (specify)	су		23d. Date of Month	*
<u>α</u>	v requires that the de been signed by the s should be detached	y Ph	Part II. Other significant condition	ons contributing to death	n but not resulting in the	underlying cause g	ven in Part I.	23e. Did to	bacco use contribu	ute to the cause of death?
rds	requires een sign nould be	q pa	Hypertens	Lon				1 🗆 Y	′es 2□No 3	□ Probably 4 Hunknown
000	s bee	Completed						24a. Was		re autopsy findings available
Re	The tav ate has page 2:	omp						autop perfor	rmed? dea	r to completion of cause of th? Yes 2⊡ No
ta	ician: Th certificate rector, pag	0	25. Was case referred to medica				26. Place of Dea			
	ys diis	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 XInpa	atient 2 ER/Outpat	ient 3 DOA	ther: 4 🗆 Nursing H	ome 5 🗆 Resid	dence 6 Other	(Specify)
o uc	fter ne		27. Manner of Death  1 X Natural 5 ☐ Pendir		njury 28b. Time Day Year) Injury	/ Wo	ury at ork? ⊒Yes 2 □ No	28d. Describe h	now injury occurred	
Division of Vital Records,	To the Hospital or Attanding within 24 hours after death.  To the Funaral Director: Afte completely filled in by the fune	Certification;	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	Injury - At home, farm, etc. (Specify)		-	28f. Location (S City or Tox		or Rural Route Number,
>	e Hospita 24 hours e Funaral letely filled	edical C	29a. Certifier 1 Certifyir (Check only one)	ng Physician: To the be Examiner: On the basis and manner	s of examination and/or	ath occurred at the investigation, in my	time, date and place, opinion, death occur	, and due to the orred at the time,	cause(s) and mann date and place, and	er as stated. I due to the cause(s)
	To th To th compl	Me	29b. Signature and title of certifie	г		29c. Licer	se number		29d. Date signed (	Month, Day, Year)
			Ven	-2-		D	54635		May 6,	2005
			30. Name and address of person						Marvil and	20850
			Michael Cett		01 Medical		rive Koc	KAITIE,	maryiand	20030
	Sta	ite	31. Date filed (Month, Day, Year)	2005 Res	strar's Signature	anti				

			1 - For State Registrar	State o	f Marylaı	•	artment rtificate			and M	lental Hygi	ene g. No. 00	S. Trail	173	18
	Physici	an	Decedent's Name (First, Middle, La	st)							2. Date of Death Month	Day	Year	3. Time of E	Death
	/Media		LINA		Re	OSENGA				MAY 6, 2		4:00 P	) M		
}	Examir	er	4a. Facility Name (If not institution, giv EDEN HOME	e street and nur	nber)				Location o		,	4c. County of		COMP	,
	Formul		5. Social Security Number 6. S	Sex	7. Age (In yrs.	. last birthday)	If Under		ER SP					GOMERY	
	Funeral Director			□M 2¥0F	9		Months	Days	Hours	Min.	8. Date of Birth (Month, Day, 11/03/19	Year)	CAN	ace (State or ry) ΔΠΔ	roreign
	P .		Usual Residence of Decedent												
	arylar show	<u>_</u>	10a. State 10b. County		10c. C	ity, Town or Lo	cation						10	d. Inside City	
	the Marylan 28e-f show	ecto	MARYLAND MONTGOMI	ERY	ROC	KVILLE								1 Tyes 2	
	e or	Ö	10e. Street and Number 518 NEW MARK ESPLA	MADE			10f. Zip		0050		10	g. Citizen of W		•	
	leath	era	11. Marital Status		dent Ever in U	J.S. 13.	Was Decede		0850	nin? (Sn	acity Yes or No-		J.S.A		
മ	r iter	Fun	1 Never Married 2 Married	Armed Fo	rces?					, Puerto	ecify Yes or No- Rican, etc.)		k, White, et	itc.	
8	rel', o	l by	3 XWidowed 4 □ Divorced	1 ☐ Yes If Yes, Giv Year or Da	ates:		1 ☐ Yes 2	No	Specify:			Specify:	Specify: WHITE		
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show he Medical Examither must be notified at	etec	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual kind of work	k done d	furina most	of work	ing 1	6b. Kind of Bus	iness/Indu	ustry		
12	within and the same of the sam	mpi	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.		VOT use retired)						-11-	
0 0	filed v Hygie ther t	3	ပ္	12 17. Father's Name (First, Middle, Last,	)			HOMEMAKER		r's Name	e (First, Middle, M		OWN HOME		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then "neturel", or items 23e or 28e-f show any njury or gaher treumatic event, the Mcdical Examiner is ust be notified at once.	o Be	JOSEPH			ENGELI	BERG		EVA		,	aroon borname	,	FFLER	
ary	shou ind M mar	1	19a. Informant's Name/Relationship (	Туре, Print)		19b. Mailir	ng Address	(Street a	and Numbe	r or Rura	al Route Number,	City or Town, S			
Ž	and 2		NATALIE NELSON MEI	LNICK/DA	UGHTER	518 N	IEW MA	RK 1	ESPLA	NADE	ROCKVI	LLE. MA	RYLA	ND 20	850
ore	2 H 2 H 2 H		20a. Method of Disposition 1 反 Burial 2 ☐ Cremation 3 反	Domaval from	20b.	Place of Dispo	sition (Nam	e of		[		0c. Location - 0			000
Ĕ	Pag ment ent: I		'4 □Donation 5 □ Other (Specif		CL	CEME	ERY PA	.KK	0.	5/08	/2005 B	IRMINGH	IAM, 1	MICHIG	AN
Baltimore,	eparti eparti nporti ny nji	21. Signature of Funeral Service Licensee  22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, IN										- 1			
-	Ø □ 12 4 0		THUNG	<i>)</i>		111	_70_R0	CKV:	ILLE	PIKE	, ROCKVI	LLE. MA	RYLAN	ND = 20	852_
			23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Betwee Onset and Dea											een	
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)			TERY D	SEASE							O YEAR	
	Examiner				Or as a consec		CEACE	,					- 2	e case a sa	
		Jer	Sequentially list conditions,	or as a consec	ULAR DI quanca of).	LDEADE	,					- 12	JEAR	5	
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												
oʻ	The law requires that the death certificate be executed that been signed by the attending physician and page 2 should be detached for use as the burial-transit		resulting in death) Last	quence of):											
8760,	ate b	Physician/Medical		_ d.											
9	eath certific attending pl	/Mec	IF FEMALE:	220 If you out	nama af araga	2004									
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live b	33c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)						23d. Date of delivery  Month Day			ar	
P.O.	that the de led by the a detached f	nysic	1 ☐ Yes 2 🕱 No 9 ☐ Unknown 9 ☐ Unknown												
	s that ned b e deta	by Pr	Part II. Other significant conditions of	ontributing to de	eath but not res	sulting in the u	nderlying ca	use give	n in Part !.		23e. Did toba	acco use contrib	oute to the	cause of dea	ath?
rds	w requires been sign should be	ed b	ECTAL CANCER					1 ☐ Yes 🏂 No 3 ☐ Probably 4 ☐U				known			
Records,	aw requas been 2 should	piet			24					24b. W	ere autops	sy findings av	/ailable		
		Completed									autopsy perform 1 Tes 2	ed? de XINo 1[	eath? Yes 2	sy findings av pletion of cau !□ No	ise of
Vital	Physicien: The this certificate ral director, pages	Be (	25. Was case referred to medical examiner?								Check only one	)			
<b>J</b> o	d is	2	1 ☐ Yes 2X No 27. Manner of Death			ER/Outpatien					me 5 Residen			GROUP I	HOME
UC.		ion	1 X Natural 5 ☐ Pending		h, Day Year)	28b. Time of Injury	M	Work	at :? ∕es 2 □ N		28d. Describe hov	v injury occurre	d		
Division of	ten leat tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be		of Injury - At h	ome, farm, str			03 2 🗀 1		28f. Location (Stre	et and Number	r or Rural I	Route Numbe	or
2	after after Dire	erti	4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Ro City or Town, State)												
C-	Hospitel 24 hours a Funerel I stely filled		29a. Certifier Certifying Ph	ysician: To the	best of my kno	owledge, death	occurred a	t the tim	e, date and	place,	and due to the cau	use(s) and man	ner as stat	ted.	
67	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	ledical	(Check only 2 Medical Exam	and mann	isis of examina er stated.	ation and/or inv				n occurr					
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	4			29c.		number	7	296	d. Date signed			
	10		10800					טע	05913	) / 		MAY 7,	2005	J	
			30. Name and address of person who KELLY COWEN, M.D					ROC	KVTI I	E. N	1ARYLAND	20854			
	Sta	e	31. Date filed (Month, Day, Year)					100	A T IT I	۱۱ و ۱۱۰	TAKI DAMD	20034			
	Registr	-	MAY 1 0 20	05	we to	ature	W.								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 2. Date of Death 1 Decedent's Name (First, Middle 1 ast) 3. Time of Death May 6, Year 2005 **Physician** Joseph ROEMER 2:40 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Foxchase Nursing and Rehab. Silver Spring Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Aug • 18, 1908 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** New York 1**7** M 2□F 96 053-20-9559 Yrs. Director Usual Residence of Decedent with the Maryland show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Silver Spring Directo Maryland Montgomery or 28e-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20910 United States 1421 Highland Drive Items 23a Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours atter cannot of Heatth and Mental Hygiene.
ant: If item 27 is marked other then "naturel", or Iter
ury or other treumatic event, the Medical Earth arry or other treumatic event, the Medical Earth arry. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 21215-0036 Specify: white Completed by 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elias Roemer Molly Nussbaum 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1421 Highland Drive, Silver Spring, MD 20910 19a. Informant's Name/Relationship (Type, Print) Peter Roemer, Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Importent: If it eny injury or o 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State Mt. Lebanon Cemetery | 05/06/05 Adelphi, MD 4 □ Donation 5 □ Other (Specify) 10 Figeral Service Licenses Porchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part Sheef the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Advanced Age /Medical Due to (or as a consequence of): Examiner Myocardial Infarction Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical the phy nse s IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part IJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ pe 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 rmed? 2 ☐ No 1 Yes the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1X Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) tilled in by 4 - Homicide within 24 hours a

To the Funerel I
completely tilled 29a. Certifier 1[XCertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 58597 05/07/05 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8609 - 2nd Avenue, Suite 404B, Silver Spring, MD 20910 Shahryah Davari, M.D., 32. Figistrar's Signature 31. Date filed (Month, Day, Year) 0 2005 State Registrar

			1 - For State Registrar	Adiabata ta i			-	artment of F			Reg. No	2001	17320		
	Physici /Medi		Decedent's Name (First, Middle, Last)     SELMA R. ROSENHACK						2. Date of Death Month MAY			, 2005	3. Time of Death 1:05A M		
	Examir		4a. Facility Name (If not inst		street and numbe	r)		4b. City, Town, o		ath		. County of Dea			
			WOODS IDE CE  5. Social Security Number	NTER 6. Se	y 7/	Age (In yrs. Ia	st hirthday)	SILVER If Under 1 Year	SPRING  If Under 24 Hi	S.   9 Date of Bi		MONTGOM			
l.	Funeral Director		112-56-5025 Usual Residence of Decede	10	_M 2[ <b>X</b> F	90	Yrs.	Months Days	Hours Mi		ay, Year) -1914	4 P	rthplace (State or Foreign ountry) OLAND		
,	yland 10W		10a. State 10b. Co			10c. City	, Town or Lo	cation					10d. Inside City Limits		
	B - f s f	ctor	MD MO	NTGOM	ERY		SILV	ER SPRIN	G				1 ☐ Yes 2 📉 No		
13	n with the 23a or 28 31 be no	Funeral Director	10e. Street and Number 9101 2ND	AVENUI	TUE 10f. Zip Code 10g. Citizen of What USA								ountry?		
036	De liled within 72 nouis arter deain with rine maryland ital Hygiene. All Hygiene do othar than "natural", or items 23a or 28a-f show evant, the Modical Examiner must be notified at	þ	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes 2 If Yes, Give  1 Year or Date:			s? ¶No		Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2X No	lispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - Am Black, Whi			
٠ -	natur	eted	15. Dec (Specify only I	edent's Edu	ication		16a. Decec	lent's Usual Occup	ation	nrkina	16b. K	ind of Business	s/Industry		
21215-0036	e illed within at Hygiene. othar than "l vant, ine Mas	Completed	Elementary/Secondary (0	College (1-4o	r 5+)	life. L	OO NOT use retired MAKER	1)	orking	רמם	[VATE				
S S	Hygie Hygie othar ant, II		17. Father's Name (First, Mi	ddle, Last)			HOFIL	CIFACEIC	18. Mother's N	ame (First, Middle					
<u>a</u>	should be nd Mental marked c	To Be	ISADORE			RUBENS	STEIN		ANNA	TUCHMA	IAN				
Maryland	" = 3		19a. Informant's Name/Rela	tionship (T)	rpe, Print)			•				y or Town, State, Zip Code)			
Σ : Δ'	and ealth m 27 her tr			ANN -	DAUGHTE			508 GOLDLEAF DRIVE, BETH							
Baltimore,	permit. Pages 1 and 2 should Depurtment of Health and Men Important: If itam 27 is marke any njury prother traumatic once.		20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 ▼ Removal from State  '4 □ Donation 5 □ Other (Specify)  Date  Cemetery, crematory or other place)  MT. HEBRON CEMETERY  MAY 9, 2005									20c. Location - City or Town, State FLUSHING QUEENS, NY			
Balt	Deportri		21. Signature of Funeral Service Licensee  22. Name and Address of Facility DANZANSKY—GOLDBERG MEMORIAL CHAPEL, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852												
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate shock, or heart failure.												
ΙΙ,	nysician Medical	6 //	Immediate Cause (Final disease or condition DEMENTIA										Onset and Death YEARS		
			resulting in death)	-	Due to (or as a consequence of):										
	xaminer	_	Sequentially list conditions, if any, leading to immediate causa. Enter Under your		b. SEIZURE DISORDER Due to (or as a consequence of):								YEARS		
	physician and s the burial-transit	ical Examiner	Cause (Disease of injury that initiated events resulting in death) Last  C. ATHEROSCLEROTIC HEART DISEASE  Due to (or as a consequence of):										YEARS		
O. Box 68	ins aw requires man use deam cerminates the has been signed by the attending physoage 2 should be detached for use as the	Physician/Medic	Part II. Other significant conditions commoding to death out not resulting in the underlying cause given in Part I									23d. Date of de Month	livery Day Year		
S,	igned be deta	by P							en in Part I.	23e. Did 1	obacco u	use contribute to	o the cause of death?		
	been signal	ted	ANEMIA							1 🗆	Yes 2	XNo 3 □ P	robably 4 Dunknown		
		Completed								auto perfe	24a. Was an autopsy performed?  1 ☐ Yes 2 ☑ No 24b. Were autopsy findings availab prior to completion of cause of death?  1 ☐ Yes 2 ☑ No				
V 118	is certificate director, pag	Be	25. Was case referred to me examiner?	-	fospital:			Oth		eath (Check only	one)				
5	d is	2	1 ☐ Yes 2 ▼ No 27. Manner of Death		1 Inpar	tient 2 E	R/Outpatien		4 Xivursing	Home 5 ☐ Resi			ecity)		
0	r death. actor: After by the fune	tlon	1 Vanatural 5 □ P	ending vestigation	(Month, D	ay Year)	Injury	28c. Injun Worl	k? Yes 2 □ No	EGG. DGGGTIBO	now anjui	y cocurred			
5	after dea Diractor	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)					
<b>b</b>	4 hours Funaral	Medical Co	29a. Certifier TO Cer (Check only one)	tifying Phy dical Exami	sician: To the bes	of examination	rledge, death on and/or inv	occurred at the timestigation, in my of	ne, date and plac pinion, death occ	ce, and due to the curred at the time,	cause(s)	and manner as place, and due	s stated. e to the cause(s)		
	within 2 To the	Mec	29b. Signature and title of co	ertifier	und manner :	rateu.		29c. License	e number		29d. Dat	te signed (Mont	th, Day, Year)		
,	T	l de	→ Kak		arona	`		D20	108		M	IAY 8, 2	2005		
			30. Name and address of per RAKESH ARORA		-				JITE 222	. BOWIE	MD	20715			
83	Sta	ite	31. Date filed (Month, Day,	Year)	32 Regis	trar's Signatu		all I							

Physicia	an	1. Decedent's Name (First, Middle, La John Philip S			2. Date of Deat Month May 4,	n Day 2005	Year	3. Time of Death 09:45 a				
/Medic Examin		4. E. Sh. Mary Mark institution of a street and numbers				r Location of Death		4c. County Kent	4c. County of Death			
Funeral Director		219-07-3212	- G	(In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 22		9. Birthp Cour MD	llace (State or Forei ntry)		
Maryland -f ehow		Usual Residence of Decedent		Oc. City, Town or Lo Chesterto			Sept. 24,191			0d. Inside City Lim 1 ☐ Yes 2 🔀 I		
h with the Ma 3a or 28a-f	al Director	10e. Street and Number 2020 Heron Poin	t		10f. Zip Code 21620		1	0g. Citizen of V USA	What Cour	ntry?		
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or Items 23a or 28a-f ehow sumatic event, the Medical Examinating to natitled at	by Funeral	4 Deliver Married Of Married 1 Wes 1 Deliver			Was Decedent of Hilf Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Bla	14. Race - American Indian, Black, White, etc. Specify: White			
ithin 72 ho ne. nan "natur Nedical B	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	dent's Usual Occup kind of work done DO NOT use retired ge Advoca	pation during most of working d)		6b. Kind of Business/Industry						
2 should be filed with and Mental Hygiene. Is marked other that aumatic event, the h	To Be Cor	17. Father's Name (First, Middle, Las John P. Stafford	18. Mother's Name  Leah Hade		Milit Maiden Suman ah Hado	10)						
s 1 and 2 should f Health and Men item 27 is marke other traumatic	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co.  7745 Waterview Lane, Chestertown, MD 2162										
permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny Injury or other trai once.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 [ 14 ☐ Donation 5 ☐ Other (Special Control of		20b. Place of Disponentery, cre St. Paul		<sub>сө)</sub> ry Мау	7, 2005	20c. Location Cheste:				
Departition Depart		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral 130 Speer Road, Chestertown, Marylan										
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed XI within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and bear completely filled in by the funeral director, page 2 should be detached for use as the burial-transit up to the funeral director.	edical Examiner	23a. ban1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a control of the co	consequence of):  consequence of):  consequence of):	C	cenema				Onset and Death		
he death certif the attending ched for use a	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	s decedent pregnant ne past 12 months?  1							ery Day Year		
quires that t n signed by uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacc								cco use contribute to the cause of death?		
The law reate has bee page 2 sho	Completed						24a. Was a autops perfor 1 ☐ Yes	med?	Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause		
hysicien: his certific	To Be	25. Was case referred to medical examiner?  1  Yes 2	Hospital:	·	nt 3 DOA		me 5 Reside	ence 6 Oth	6 ☐ Other (Specify)			
To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After completely filled in by the funera	Certification:											
Hospite 24 hours Funere	Medical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exe	Physician: To the best of miner: On the basis of and manner state	xamination and/or it	th occurred at the tinvestigation, in my	me, date and place, opinion, death occurr	and due to the c red at the time, d	ause(s) and m late and place,	anner as s and due t	tated. the cause(s)		
2 - 2 -	2	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signe	d (Month,	Day, Year)		

		1 - For State Registrar	State of Mary		artmer <i>rtificat</i>			nd Me		jiene og. No.	005	17322	
		1. Decedent's Name (First, Middle, L	ast)					2	. Date of Deal	th Day	Your	3. Time of Death	
Physici /Medio		James A. Sayler				May				9 2005 3:1			
Examir		4a. Facility Name (If not institution, g			4b. City,	Town, or	Location of C	Death		4c. Cour	nty of Death		
		Union Memorial H	Mospital		В	alti	more				None		
Funeral			100 M 200 E	yrs. last birthday)	If Under Months	r 1 Year Days	If Under 24 Hours	Hrs. 8 Min.	Date of Birth (Month, Day,	Year)	Col	place (State or Foreig	
Director		215 07 8523	90	Yrs.				N	ov $3$ ,	1914	Mar	yland	
and *		Usual Residence of Decedent  10a, State 10b, County	10	c. City, Town or Lo	ocation							10d. Inside City Limit	
Aaryl Fsho	ō	MD		Baltimo	***						i	1⊠Yes 2□No	
the the 28a-	Director	MD None		рат сшю.		p Code			1	0g. Citizen o	of What Cou	intry?	
with Sa or	0	100 W. Universit	v Parkway			1210				Unite	d Sta	tes	
s within 72 hours after death with the Maryland speed. It have marked to the marked to the Maryland of the Maryland at an interference of the marked at the	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Dece	dent of Hi	spanic Origin	n? (Specif	fy Yes or No-	14. R	lace - Amer	icen Indian,	
r Her	Fu	1 Never Married 2 Married					n, Mexican, F	Puerto Rio	cen, etc.)		lack, White	, etc.	
hours after tural; or the	þ	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 🗌 Yes	21XNo	Specify:			Spec	<sup>cify:</sup> Wh	ite	
thin 72 hours af e. an "natural", or Medical Evan	Completed	15. Decedent's (Specify only highest g	Education	16a. Dece	dent's Usu	al Occupa	ition Jurina most of	f working		16b. Kind of	Business/I	ndustry	
within 72 ene. than "nai	npie	Elementary/Secondary (0-12)	College (1-4or 5+)				luring most of						
2 0	S	12		Int	erior	Des.	igner				chwar	tz	
uld be filed lental Hyg rked other lic event,	Be	17. Father's Name (First, Middle, Las							First, Middle, I	Maiden Sum	ame)		
0 2 2 0	ျ	Jacob Abner Sayl					Helen						
20 00 00		19a. Informant's Name/Relationship		16	•				Route Number			p Code)	
C = 10 F		Diana Sayler/Nie		6 Ua.			venue .	Balt	imore,	MD 21 20c. Locatio		our State	
0 0		1 Durial 2 Cremation 3	Bemoval from State	cemetery, crea	matory or o	other place							
Pa tmen tant:		* 4 □ Donation 5 □ Other (Spec	,,	Metro Cr						Catons			
permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice	ansee M	01044	2. Name a	nd Addres	s of FacilitH	arry	H. Wit	tzke's	Fami	ly FH Inc.	
40200		gine all	s music								City,	MD 21043	
		shock, or heart failure. List only one cause on each line.  Interval Betwood										Approximate Interval Between Onset and Death	
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/Medical Examiner		Due to (or as a consequency of):											
	_	Sequentially list conditions,	b. Due to (or as a co	ova cu	elle	0.0	ceste	ues				gan	
led isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	97-	tens-								Cours	
xecul and	xan	that initiated events resulting in death) Last	c. Due to (o as a co		231	_						7.000	
cate be executed physician and the burial-transit									- 1				
ficate physis the	edicai		0.										
eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr							23d. (	Date of deliv	ery	
leath atte	cial	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at time		⊒Ectopic p ⊒ Other <i>(s</i> ;						Month	Day Year	
at the de by the a tached t	hysi	9 Unknown	9□ Unknown										
2 P P	by Pl	Part II. Other significant conditions	contributing to death but no	ot resulting in the u	inderlying o	cause give	en in Part I.		23e. Did tob	oacco use co	entribute to	the cause of death?	
quire n sig uld b	D D							_	1 🗆 Y€	s 2 🗆 No	3 ☐ Pro	babiy 4 Dunknown	
ician: The law requires to certificate has been signe rector, page 2 should be or	Completed								24a. Wasa	n 24t	o. Were aut	opsy findings available	
sician: The law certificate has l irector, page 2 s	E							_	autops perform 1 Yes 2	y ned?	death?	mpletion of cause of	
	C	25. Was case referred to medical					26 Place of	f Death ((	1 ☐ Yes 2		1 🗆 Yes	2121490	
	0 8	examiner? 1 ☐ Yes 2 XNo	Hospital: 1 Inpatient	2X ER/Outpatier	nt 3 Do	OA Othe			5 ☐ Reside		ther (Speci	(v)	
if or Attending Physafter death. Director: After this 3 in by the funeral di	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Yea			28c. Injury Work	at		d. Describe ho				
Attending I death. ctor: After y the funer	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigati		ai) injury	М		res 2□No	,					
or Attending Physician: after death. Director: After this certific in by the funeral director.	ific	3 Suicide 6 Could not 4 Homicide determine		At home, farm, str	reet, factor	y, office		281	Location (St.	ocation (Street and Number or Rural Route Number, ity or Town, State)			
spital or At ours after veral Direc filled in by	Certification:												
ospil hour uneral		29a. Certifier 1 Certifying F	Physician: To the best of my aminer: On the basis of exa	y knowledge, deat	h occurred	at the tim	e, date and p	place, and	d due to the ca	ause(s) and i	manner as	stated.	
To the Hospital or Attention within 24 hours after death To the Funeral Director completely filled in by the	Medical	one)	and manner stated.	animation alloyof III				CCCUITEC					
To the To the Compl	Σ	29b. Signature and title of certifier	. /	\$		c. License			25	9d. Date sign			
		marque	We huran	u ans	15	०४००	093			May 1	0, 20	05	
}		30. Name and address of 6 rson wh		(Item 23a) (Type,	Print)	_	ch a i	0	115				
		morgierite	I. Walch	M.D.	400 E	: -33	· 5t.	13	xlt:n	are v	137 9	81918	
Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's \$		1								

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Marylan		artment of H			giene Reg. No.	40	1 7 0 1	
	Dharaiai		1. Decedent's Name (First, Middle, Las			2. Date of Death Month Day Year 3. Time of Death						
	Physici /Medio		Evelyn Tea	at Smothers				May 2	2005		22:19 Mp	
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of De	eath	4c.	County of Death		
			Southern Maryla			Clinto	on If Under 24 F	Irs. 8. Date of Bin	Pr	ince G	eorge's	
	Funeral		5. Social Security Number 6. Se	ex	Yrs.	Months Days		lin. (Month, Da	y, Year)	Cou	place (State or Foreign intry)	
	Director		217-58-1590 Usual Residence of Decedent					Oct.	1 12	JI Mar	yland	
	yland		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits	
	e-f sl	ctor	Maryland Prince	e George's	C1in	ton					1Ã Yes 2 ☐ No	
	er 28	Oire	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Cou	intry?	
	death with the Maryland ms 23a or 28e-f show rmust be notified at	Funeral Director	9502 Gwynndale				735			USA		
	er de	nue	11. Marital Status	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 🖾 No	.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or No ento Rican, etc.)		<ol> <li>Race - Ameri</li> <li>Black, White</li> </ol>		
36	rs att	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:			Specify: B	1ack	
5-0036	n 72 hours atter death with the Marylan "neturel", or items 23e or 28e-1 show sdisal Examinat must be notified at	ted	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	ation	. 41	16b. Ki	nd of Business/fr	ndustry	
215	hin 7.	pie	(Specify only highest gra	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	during most of d)	working				
2121	ed wil	Completed	12th	0	Ent	reprene					ir Shop	
pu	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle,				
yla	12 should be filed within "h and Mental Hygiene." 7 is marked other then "Ireumatic event, the Men	ပု	Clayton Tea					lvania				
Maryland	12 sh h and 7 is m treum		19a. Informant's Name/Relationship (7					Rural Route Number				
	ges 1 and 2 should be filed within to of Health and Mental Hygiene. If item 27 is marked other then or other treumatic event, the Me		Monterious Dixo	20b. P	Place of Dispe	olis, Md. 21403  20c. Location - City or Town, State						
Baltimore,	Pages nent of l ant: If it		1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify			matory or other place e Memor	lai¦ _ ,	6 /05		·		
ij	교 든 분 중		21 Signature of Funeral Service Licensee									
Ba	Depared Important any ir		Zanza H.T	Reese MOOY8		m. Rees	e & Sc	ns Morti	uary	P.A.	01	
	13.33		23a Part1. Enter the disease, or companies shock, or heart falure. List only	lications that caused the deat							Approximate Interval Between	
	Physician .		Immediate Cause (Final disease or condition	S a a T							Onset and Death	
7	/Medical		resulting in death)	Due to (or as conseq	uence of):	14						
Е	Examiner		Sequentially list conditions.	. Multi	ple	Dicu	(b) Te	Way	in	4 8		
	sit s	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uance of):							
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687	ficate p phys is the	73		, d,								
Вох	leath certifica attending ph	hysician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	ancy	<b>7</b>			1	23d. Date of deliv	rery	
	0 0 0	icia	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		⊒Ectopic pregnancy ⊒ Other (specify) _				Month	Day Year	
P.0	t the by th ache	hys	9 □ Unknown									
	res tha igned l be det	ру Р	Part II. Other significant conditions o	ontributing to death but not res	ulting in the u	inderlying cause giv	en in Part I.				the cause of death?	
ord	w require been si should i	ted	Memi	2				10	Yes 2	□No 3□Pro	bably 4 Arknown	
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/ita	ysicien: Th is certiticate director, pag	Be	25. Was case referred to medical ( examiner?	I I ii - I		0.1		Death (Check only o				
of.	Physicien: this certitic ral director,	မ	1 ☐ Yes 2 ₺No	and the second s	ER/Outpatie			g Home 5 Resi			fy)	
n C		on	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2 □ No	280. Describe	now injur	v injury occurred		
Division	Attending r death. ector: Attered by the fune	lical	2 Accident investigation 3 Suicide 6 Could not be		ome, farm, st			28f. Location (	Street an	d Number or Rui	al Route Number,	
οį	spital or Attenous after deat ours after deat ieral Director: tilled in by the	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	(y)	,,,		City or To	wn, State	)		
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director:	aic	29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	owledge, deal	th occurred at the tir	ne, date and pl	ace, and due to the	cause(s)	and manner as	stated.	
	To the Hos within 24 h To the Fur completely	edical	(Check only 2 Medical Exam	niner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my o	pinion, death o	ccurred at the time,	date and	f place, and due t	to the cause(s)	
	To the To the Comp	ž	29b. Signature and title of certifier			29c. Licens	e number	Q		te signed (Month,		
			1 / 15til	1/6 ME		101	75 5	7	05	-03-	05	
		18	30. Name and oddress of person who	completed cause of death (Item	m 23a) (Type,	Print)	C	÷1.	0	C	DC 20037	
			31. Date filed (Month, Day, Year)	2 Registrar's Signa	D '	1777	204	Mern	/7 1	ve st	Dr 7 0035	
	Sta	ite	31. Date filed (Month, Day, Tear)	negistrar s olgina								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3: Time of Death May 9, **Physician** 2005 5:30 a M John James Shipley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charles 105 Ouailwood Parkway LaPlata If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Aug. 14, 1924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐XM 2 ☐ F Washington DC Yrs. 578-20-2254 80 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.
Hygiene. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits item 27 is marked other than "neturel", or items 23a or 28a-f show other treumetic event, it e Modical Examinar must be inclifted at 1 TYes 2 No Director Maryland Charles LaPLata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 Quailwood Parkway 20646 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carmen Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fount of Health and Mental Fint: If item 27 Is marked of Anna Elizabeth Nolte John Samuel Shipley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Quailwood Parkway, LaPlata, Md. 20646 Annie M. Ollup Niece Date of Disposition (Name of commeter), crematory or other place) May 13,2005

Sacred Heart Catholic Church LaPlata, Maryland 20b. Place of Disposition (Name of 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Williams Funeral Home, P.A. 86600M Md. 20640 4270 Hawthorne Rd. Indian Head, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit The faw requires that the death certificate be executed Due to (or as a consequence of) Box 68760 attending physician Physiclan/Medical the 980 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No Division of Vital Records, P.O. detached the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 **N**0 Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 1 ☐ Yes 2 No 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) P 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Injury 1 Natural 2 ☐ Accident 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital within 24 hours a To the Funerel E 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe WALDORF MEELU

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

0 2005

			State of Maryland / Dep			53 64 5 m	
			1- State Registrar 5/12/05 WCHD/SH per Dr. Ce  1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg.	No.	3. Time of Déath
	Physici	an			Month	Day Year	
	/Medic		Evelyn Kailer Snyder  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	May (	08 2005 4c. County of Deat	
	Examin	er		4b. Oily, Town, or Eccation of Beauti			
	Funeral		13902 Kellen Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Hagerstown  If Under 1 Year   1 Under 24 Hrs.	8. Date of Birth	Washing	ton County
	Funeral Director		1 □ M 2 X F Q2 Yrs.	Months Days Hours Min.	(Month, Day, Ye	sai)	intry) I Jersey
	D.		220-16-1879 Usual Residence of Decedent		Aug 20	1922 1969	*
	anylar show	_	10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
	Be-f s	cto		erstown			1 Tyes 2 No
	vith th	Director	10e. Street and Number	10f. Zip Code		Citizen of What Co	•
	s 23s	rai	12213 Delwood Ave	21740		ited Stat	
	er de Item	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1  Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Amei Black, White	
36	rs aft	by F	Married 2 Married If Yes, Give  322Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes X☐ No Specify:		Specify: whi	.te
21215-0036	72 hours after death with the Maryland "neturel", or Items 23a or 28e-f show cilical Examiner must be notified at	ted		edent's Usual Occupation	166	b. Kind of Business/l	ndustry
215	를 . <b>글 를</b>	ple	(Specify only highest grade completed)  (Giv   Elementary/Secondary (0-12)   College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	ing		-
21;		Completed	12	ental Assistant		enist Off	ice
p	9 - 9 5	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Mai	den Sumame)	
Va		ည	Russell B. Kailer	Mary Br	own Kaile	r Snyder	
Maryland	2 shou and M Is mar			ing Address (Street and Number or Rur		-	
	s 1 and 2 should F Health and Mer Item 27 Is marke other treumatic			Weather Shore Hilt			
Baltimore,	0 0		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre	ematory or other place)		c. Location - City or	
ţi	permit. Pag Department Importent: I eny injury o			O Managard Address of Earling	13, 2005 H		
Bal	permit. Pag Department Importent: I eny injury o		billown a Dataulou Tr		ouglas A.		
			23a. Part1. Enter the disease, or complications that caused the death. Do not el	331 Eastern Blvd.		stown Mar	yland 21742 Approximate
			shock, or heart failure. List only one cause on each line.	/	or roopingtory arroot,		Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a	496/ TOITUR			2-4 400/5
	Examiner		Cox Donverseth	y (dileted)			5 V245
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	y can 11.00			/ 1
	cuted nd ransit	Examiner	that initiated events				
0	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
68760	The law requires that the death certificate be executed its has been signed by the attending physician and page 2 should be detached for use as the burial-transit	lical	d				
9	leath certifice attending ph I for use as ti	Med	IF FEMALE:				
Вох	attenc attenc for us	ian/	in the past 12 months?	□Ectopic pregnancy		23d. Date of deli	very Day Year
o.	at the de by the a tached	Physician/Med	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 5	Other (specify)			
٦.	res that igned by be deta		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Records,	luires n sign	d by	Atrial Fibrilletion.		1 🗌 Yes	20 No 3 □ Pro	obably 4 Unknown
00	w requir s been si should	Completed	Coconer Actor disers		24a. Was an	24b. Were aut	opsy findings available ompletion of cause of
Re	The lay ate has page 2	шо	Hundindenia		autopsy performed	?   death?	ompletion of cause of
Vital	lan: The rtificate stor, pag	0	25. Was case referred to medical	26. Place of Deat	h (Check only one)	70 103	20110
_ \	ysic is ce direc	To B	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatie	ent 3 DOA Other: 4 Nursing Ho	me <del>SE Rosidon</del> ce	e 6 5 Other (Spec	<sub>ify)</sub> Brother's
n of	ding Ph h. After th funeral		27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury Injury	of 28c, Injury at Work?	28d. Describe how i	njury occurred	house
Sio	ktendi death. ctor: A y the fu	catl	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division	or Att after de Direct	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
	Hospitel or Attending 24 hours after death. Funeral Director: After tely filled in by the fune		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place	and due to the cause	a/s/ and manner as	stated
	e Hos 24 hr e Fur letely	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or land manner stated.	nvestigation, in my opinion, death occur	red at the time, date	and place, and due	to the cause(s)
	To the Hospitel of within 24 hours all To the Funeral D completely filled it	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month	. Day, Year)
•			Ms ms	0.0056413	U	5/11/05	
111			30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)	K 0 = 0-	047	1170-
JH.	-0+4		DR, S, SAXENA 3 BYRKIT  31. Date filed (Monita Gay, Year).  32. Bygistrar's Signature	DR WILLIAM	SPORT	IVI) -	4173
	Sta Registr			rede			
			Lancon N. D	10000			

				1 _ State	/ Department of Health and Mer  Certificate of Death	/	17326
				Registrar  1. Decedent's Name (First, Middle, Last)		Reg. No.	3. Time of Death
_	· N	Physici /Medi		MARGARET ALBERTA SMITH		Month Day Year	02-011
•		Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dea	th
				tahrney keedy Nursing Hon	ne Boonsboro	Wash	ington
		Funeral		5. Social Security Number 6 Sex 7. Age (In yrs. las	st birthday) If Under 1 Year If Under 24 Hrs. 8.  Yrs. Months Days Hours Min.	Date of Birth (Month, Day, Year) 9. Bir	thplace (State or Foreign ountry)
		Director		726-16-9726   1   M 2   Z   86	113.   F	EB. 2, 1919 PEN	INSYLVANIA
		land			Town or Location		10d. Inside City Limits
		within 72 hours after death with the Maryland ene. then "neturel", or ttems 23a or 28e-f show the Medical Examinar roust be notified at	tor	MARYLAND WASHINGTON	BOONSBORO		1 X Yes 2 ☐ No
7		or 28	Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	ountry?
Smith		23a c	aiD	7 MAPLE AVENUE	21713	U.S.A.	
Š		ter dea ttems	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	y Yes or No- an, etc.) 14. Race - Ame Black, Whi	
A)	36	or tt	y Fu	1 ☐ Never Married 2 🛣 Married 1 ☐ Yes 2 🛣 No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:	Specific	
R	00	hour:	d by	3 Widowed 4 Divorced Year or Dates:			VHITE
7	15	a within 72 hours after death with jiene. in then "neturel", or tems 23a or then "neturel", or tems 23a or then "neturel".	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business	/Industry
3	12	tiled within Hygiene. Sther then sent, the Ment	E C	Elementary/Secondary (0-12) College (1-4or 5+)	CLERK	RAILROA	D
Alberta	D		BeC	17. Father's Name (First, Middle, Last)		irst, Middle, Maiden Sumame)	
7	lan	lid be fenta rked ric ev	To B	GARNET KING HELLER	NELLIE CAT	HERINE WERDEBAUG	H
+	Maryland 21215-0036	and Name		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Ro	oute Number, City or Town, State,	Zip Code)
Margare		ges 1 and 2 should be tile t of Health and Mental Hy If item 27 is marked oth or other treumatic event		BURMAN H. SMITH/SPOUSE	7 MAPLE AVENUE, BOONSBOR	O, MARYLAND 217	13
2	altimore,	tof He		20a. Method of Disposition 1 ☒ Burial Cremation 3 ☐ Removal from State	ce of Disposition (Name of Date netery, crematory or other place)	20c. Location - City or	Town, State
É	Ë	Pages ment of tent: If it jury or o			SBORO CEMETERY 05/12/2	2005 BOONSBORO,	MARYLAND
$\leq$	3ali	permit. Pag Department Importent: t any injury o		21. Signature of Funeral Service Idense Paul M. Dea		606 Old national	
_		40 = # Q		aurich		oonsboro, Maryla	
_				23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac or re	spiratory arrest,	Approximate Interval Between Onset and Death
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Cancer		2 X
		Examiner		Due to or as a consequer	ice of):		2/
		الحان	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequent	ice of):		2 4
		uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.			
	ó	be executed sician and burial-transit		resulting in death) Last Due to (or as a consequen	ice of):		
7	8760	ate V.	Physician/Medical	d			
Smid	9	artifica ing pl e as t	Med	IF FEMALE:			
Ž	Вох	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnance 1 Live birth 2 Fetal de	eath 3 Ectopic pregnancy	23d. Date of del Month	ivery Day Year
(V		he de the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	th 5 Other (specify)		24)
B	P.0	w requires that the death certific: been signed by the attending pl should be detached for use as t		Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
Riberta	rds	quires n sign	d by			1 ☐ Yes 2 ☐ No 3 ☐ Pr	obably 4 Dünknown
10	000	law rec as bee 2 shou	iete			24a. Was an 24b. Were au	itopsy findings available
3	Re	vicien: The law certificate has b rector, page 2 st	Completed			performed? prior to	completion of cause of
,	ita		0	25. Was case referred to medical	26. Place of Death Cl		2   NO
2	<b>f</b> <	d is	To B	examiner? 1 ☐ Yes 21√2 No Hospital: 1 ☐ Inpatient 2 ☐ EF	VOutpatient 3☐ DOA Other: 4 Nursing Home	5 Residence 6 Other (Spec	cify)
Z	0	ling Phye n. Atter this funeral dii		27. Manner of De th  1 SA Natural 5 Pending (Month, Day Year)  28. Date of Injury (Month, Day Year)		Describe how injury occurred	
(2)	Sio	Attending Physicien: r death. sctor: Atter this certification in funeral director.	cati	2 Accident investigation	M 1 Yes 2 No		
Margaret	Division of Vital Records,	or At atter of Direction by	Certification;	4 Homicide  4 Homicide  4 Homicide  4 See Place of Injury - At home building, etc. (Specify)	a, farm, street, factory, office 28f.	Location (Street and Number or Ru City or Town, State)	ıral Route Number,
2	_	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: Atter th completely filled in by the funeral	edicai C	29a. Certifier (Check only (Check only and Continuous)  1  Certifying Physician: To the best of my knowle and continuous for the continuous forms. On the basis of examination and continuous forms.	edge, death occurred at the time, date and place, and	due to the cause(s) and manner as	stated.
		thin 24	Medi	and manner stated.			
	•	To Wit	-	29b. Signature and title of certifier	29c. License number	29d. Date signed (Monti	n, Day, rear)
				20 Name and address of source the source of	075353	3//0/1	
	3	4-10		30. Name and address of person who completed cause of death (Item 2: Khalid M. Waseem, M.D. 1126 (	Opal Court, Hagerstown, I	Maryland 21742	
		Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	8		
		Registr	ar	MAY 11 2005	· Sparke		

_		_	1 - State Registrar Ce	artment of Healt rtificate of Dea	ath	Re	g. No.	5   7327
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  Emma Josephine SOCKS  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Local		2. Date of Death Month	Pay JY 4c. County of	
	Funeral Director		Washington County Hospita1  5. Social Security Number 6. Sex 1 M 25 M 7. Age (In yrs. last birthday, 80 Yrs.	Hagerstow If Under 1 Year   If	nder 24 Hrs.	8. Date of Birth (Month, Day, NOV 22,	Washin Year) 1924	ngton b. Birthplace (State or Foreign Maryland
	B Maryland a-f show	ctor	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L           Maryland         Washington         Hagerstor					10d. Inside City Limits 1 ☐ Yes 25 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event. If a Marylocal Examiner, and the traillifted an once.	by Funeral Director		10f. Zip Code 217 Was Decedent of Hispanili Yes, specify Cuban, Me				
21215-0036	n 72 hours afte "natural", or l	Completed by Fi	(Specify only highest grade completed) (Give	1 ☐ Yes 2 ☒ No Specification	ecify: I most of working	g 1	Specify:	white ness/Industry
and 212	d be filed withing that Hygiene.  ed other than sevent, it sells	Be	Elementary/Secondary (0-12)   College (1-4or 5+)	nemaker			her ov Maiden Sumame) th Clarl	wn home
e, Maryland	and 2 shouk lealth and Me m 27 Is mark har traumatic	10	19a. Informant's Name/Relationship (Type, Print)  Jack R. Socks, Jr. – son  1314		say Road	Route Number, d, Green	City or Town, Stacestle,	ate, Zip Code) Pennsylvania 17225
Baltimore,	permit. Pages 1 Department of P Important: If ite any injury or ot once.		1 ■ Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)	natory or other place) Cemetery  Name and Address of F	May 1	11, 005 E		ty or Town, State wn, Maryland Home
	cate be executed  Medical Examiner the burial-transit	licai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on such line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease) or impury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):		ch as cardiac or	respiratory arre	st,	Approximate Interval Between Onset and Death
.O. Box 6	the death certific: y the attending pl ched for use as t	Physician/Med		⊒Ectopic pregnancy ☑ Other (specify)			23d. Date o Month	
l Records, P.	sician: The law requires that the death certificate be executed centificate has been signed by the attending physician and lirector, page 2 should be detached for use as the burial-transit	Completed by Ph	Part II. Dther significant conditions contributing to death but not resulting in the the significant conditions contributing to death but not resulting in the transfer of the significant conditions contributing to death but not resulting in the transfer of the significant conditions contributing to death but not resulting in the transfer of the significant conditions contributing to death but not resulting in the transfer of the significant conditions contributing to death but not resulting in the transfer of the significant conditions contributing to death but not resulting in the transfer of the significant conditions contributing to death but not resulting in the transfer of the significant conditions contributing to death but not resulting in the transfer of the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributed to the significant conditions contributed to the significant conditions	inderlying cause given in F	Part I.	1 ☐ Yes 24a. Was an autopsy perform	s 2 No 3	to the cause of death?  Probably 4 Unknown  re autopsy findings available of to completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of the cause of the caus
=	or Attanding Phy Ifter death. Director: After this in by the funeral d	Certification: To Be C	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 4 Homicide  28a. Date of Injury (Month, Day Year)  28b. Time of Injury (Month, Day Year)  28b. Time of Injury (Month, Day Year)  28b. Time of Injury (Month, Day Year)	ont 3 DOA Other: 4[ if 28c. Injury at Work?  M 1 Yes	Nursing Hom 28 2 □ No	8d. Describe hov	nce 6 Other	(Specify) or Rural Route Number,
:	To the Hospital or Attan within 24 hours after deat To tha Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, dea 2 Medicel Examiner: On the basis of examination and/or in and manner stated.  29b. Signature and title of certifier	h occurred at the time, dat vestigation, in my opinion, 29c. License num	, death occurred	d at the time, da	te and place, and	d due to the cause(s)  Month, Day, Year)
)	<i>l∼ / O</i> Sta Registr		30. Na e and address of person who completed cause of death (Item 23a) (Type GUD FIX F. PURA 3 6 0  31. Date filed (Month, Day, Year)  MAY 0 9 2005  32. Registrar's Signature		9824 T. 14	AGERS	May	7, 2003 4, red 21740

			4	partment of Health and Mental Fertificate of Death	Hygiene 005 17328
П	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Month	Death 3. Time of Death
	/Media		TONYA HALES SCHULTZ	May 5.	
	Examir	ier	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			32140 Spearin Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Salisbury ay) If Under 1 Year   If Under 24 Hrs.   8. Date of	Wicomico  Birth
	Funeral Director		220-86-9589 1□M 2√F 39 Yrs	Months Days Hours Min. (Month,	Birth 9. Birthplace (State or Foreign Country) 9-1965 SALISBURY, MD.
			Usual Residence of Decedent	1111	TOOS PRETEDENT, III.
	rylan how		10a. State 10b. County 10c. City, Town o	r Location	10d. Inside City Limits
	aa-f s	cto	MD WICOMICO SALISBU	JRY	1 ☐ Yes 2 No
	or 28	Olre	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	s 23a	ral	32140 SPEARIN ROAD	21801	USA
	them them	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 X Married  11. Yes 2 X No.	<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> </ol>	No- 14. Race - American Indian, Black, White, etc.
36	urs af	by F	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:	Specify: WHITE
215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show Its Madical Examinar must be notified at	ted	15. Decedent's Education 16a. De	ecedent's Usual Occupation	16b. Kind of Business/Industry
215	thin 7	old (	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of working e. DO NOT use retired)	
2	ygien ygien ser th	Completed	12	GROWER	POULTRY
Maryland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, Ire Me	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mide	dle, Maiden Sumame)
Z	ould Mer narke	To	KENNETH EVERETT HALES	HELEN JONES	7.0
Z	d 2 sl th and 7 is r traur			ailing Address (Street and Number or Rural Route Nu	
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, Ire Madical Examinar must be notified at		20a Method of Disposition 20b. Place of Di	SNOW HILL ROAD, SALISBU	20c. Location - City or Town, State
JO L	Pages nent of I int: If its iry or o		Aburial 2 Cremation 3 Hemoval from State	crematory`or other place) IVE CEMETERY 05-14-2005	SNOW HILL, MARYLAND
Baltimore,			21. Signature of Euneral Service Licensee	22. Name and Address of Facility BOUNDS FU	
Ä	permit. Departr Imports any inj		Malisa Hour Bellet	705 EAST MAIN STREET, SAL	
2.			23a. Pant. Enter the disease, or complications that caused the seath. Do not shock, or heart failure. List only one cause on each line.		
	Physician		Immediate Cause (Final disease or condition Shot sun women	Is (2) of Head and.	Onset and Death
<	/Medical		resulting in death)  a. Due to (or as a consequence of):	(1000)	
	Examiner		Sequentially list conditions, b.		
	sit ad	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
	and I-tran	Examiner	that initiated events resulting in death) Last  Due to (or as a consequence of):		
8760,	sate be executed oblysician and the burial-transit				
687	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	d		
Xo	leath certific attending pl	Z W	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
m	death e atte	icia	in the past 12 months?  1 Vec. 2 No.  4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)	Month Day Year
P.0	that the died by the detached	hys	9 Unknown	700-275	
	res tha igned be del	ьу Р	Part II. Other significant conditions contributing to death but not resulting in the		d tobacco use contribute to the cause of death?
ord	w require been si should b			11	Yes 2 No 3 Probably 4 Unknown
Records,	e law r has be ge 2 sh	Completed		24a. W	topsy prior to completion of cause of
<u> </u>		Con		1 X Ye	orformed? death? s 2 □ No 1 ☑ Yes 2 □ No
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check on	
of	di S	To.	1 ☐ Yes 2 ☐ No		esidence 6 Tother (Specify) Scene
UQ	ding Ph h. After th funeral	tlon	1 □ Natural 5 □ Pending (Month, Day Year) Injur		it was shot
Division	death death ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be 28e, Place of Injury - At home, farm.	street factory office 28f. Location	(Street and Number or Rural Route Number,
D.	al or after	Certification:	4 Homicide determined building, etc. (Specify)	home Sallel	Town, State) 32140 spearin Rd
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, d	eath occurred at the time, date and place, and due to ti	
	the Hin 24 the Fi	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/o and manner stated.		e, date and place, and due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
•	Qn.		I hay his, mid	OCME	May 6, 2005
	59		30. Name and address of person who completed cause of death (Item 23a) (Ty		-
	<b>*</b> )		31. Date filed (Month, Day, Year) 32. Registrar's Signature	111 Penn Street Baltin	more, Maryland 21201
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 0 9 2005  32. Registrar's Signature	Small )	
	11091011		The same of the sa	alin and	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month SMERSEY Year **Physician** JOSEPH 2005 2030 \$ HAROLD mar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda If Under Year II Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Montgomery Birthplace (State or Foreign Suburban Hospital 7. Age (In yrs. last birthday) **Funeral** 1 € M 2 □ F Director Yrs 579 10 9204 91 January 26 1914 New York Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the maryran nent of Health and Mental Hygiene.
ant: If itam 27 is marked other than "natural", or Items 23e or 28e-f show ury or other traumatic avant, the Medical Exam. 1 Yes XXNo Director Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2710 East West Highway 20815 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager Vending Machine Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Sweeney Annie Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clara E. Sweeney / Wife 2710 East West Highway Chevy Chase, MD 20815 or other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Olney, Maryland Norbeck Mem Park 5/10/2005 22. Name and Address of Facility Hines Rinaldi Funeral Home 21. Signature of Funeral Service Licent ee James . 11800 New Hampshire Ave Silver Spring, MD 20904 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPTIC SHOCK **Physician** /Medical Due to (or as a consequence of): Examiner 24 Hours Isatemic Brode Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 0 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Reamont Essinger 20 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 260 No 1 Yes 2 No 1 Yes o the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27 Manner of Death 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 Suicide within 24 hours after de To the Funaral Diracto completely filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 ss of person who completed cause of death (Item 23a) (Type, Print)

BOCLIA MD 64W ROCKE Rock 00 65 Dr \$4100

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

09

2005

5-4-0

SWEENEN, HAROLD

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Lewis Calvin Solem, Sr. 2005 May 6 6:15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1X M 2□ F 483-18-2742 80 Director March 16 1925 Montana Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show ortant: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examinat must be notified at Maryland Frederick Frederick 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7423 Skyline Drive 21702 United States 12. Was Decedent Ever in U.S. Amed Forces? 1 M Yes 2 □ No If Yes, Give WW II Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or lier any injury or other traumatic auch. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Nuclear Regulatory Elementary/Secondary (0-12) College (1-4or 5+) Nuclear Auditor and Engineer Commission 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Louis Solem Tena Sanderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret S. Hurkett/ Daughter 10718 Budsman Terrace Damascus, Maryland 20872 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Mav Metropolitan Crematory \* 4 □ Donation 5 □ Other (Specify) 2005 Alexandria, Virginia 21. Signature Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Dr. Gaithersburg, MD 20877 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Chermobstructive 1 Yes 2 No 3 Probably 4 Unknown Completed 812 deficience 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 1 Yes 2 No Certification: To 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Many er of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death. To the Funeral Diractor: A investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 204115 +1 30. Name and address of person who completed cause of death (Nem 23a) (Type, Print) 20 / RUSSELL AVENUE BIRSCHBACEDUNA. GATTHERSBURG, WLD 20877 4. ROBERT 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAY 0 9 2005 Registrar

			. For		Maryland / D			=	_	•
			1 - State Registrar		(	Certificate o	f Death		Reg. No U	17331
	Physici	an	1. Decedent's Name (First, Middle, La					2. Date of De Month	aath Day Yea	
	/Media	cal	Farhan H. Sahlye			4h Cihi Tour	or Logation of Do	May 6,		3:40 P M
	Examir	ner	4a. Facility Name (If not institution, give				, or Location of De	eath	4c. County of De	
	Funeral			Sex 7.	PITAL Age (In yrs. last birth	day) If Under 1 Yea			Montgor	nery Birthplace (State or Foreign Country)
	Director		215-62-5916 Usual Residence of Decedent	1 <b>⊠</b> M 2□F	69 Y	s. Months Day	s Hours M	Sept.	17, 1935	Palestine
viand	MOL TE		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
уе Ма	8a-f s	Director		ontgomery	Silv	er Spring				1 ☐ Yes 2 <sup>X</sup> ☐ No
with th	3a or 2 st be n	al Dire	10e. Street and Number 230 Thistle Dri	ive		10f. Zip Code 209			10g. Citizen of What USA	Country?
deat	swa scon	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S.	13. Was Decedent o	f Hispanic Origin?	(Specify Yes or No	14. Race - Ar Black, Wi	nerican Indian,
:1215-0036 within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If Itam 27 Is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tes 2 If Yes, Give Year or Date	<b>⊠</b> No	1 ☐ Yes 2 🖰 N		010 (11021), 010.,	Specify: Wh	
5-0(2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/	natura lical E	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. C	ecedent's Usual Occ	supation	working	16b. Kind of Busines	ss/Industry
21215-0036 d within 72 hours aft	han a Mac	mple	Elementary/Secondary (0-12)	College (1-4	or 5+)	Give kind of work dor ife. DO NOT use reti				
ה ה	Hygie thar t nt, th		12 17. Father's Name (First, Middle, Last	)	ŀ	Iome Maint		Jame (First Middle	Self Emp] , Maiden Sumame)	Loyed
Maryland	ental ked o c eve	To Be	Hanna Sahlyeh	,				h Khoury	, maidor obmano,	
Shoul	nd M mari	-	19a. Informant's Name/Relationship (	(Type, Print)	19b. N	Mailing Address (Stre			er, City or Town, State	, Zip Code)
<b>E</b> 5	alth a		Almaza F. Sahlve	eh/ Wife	23	0 Thistle	Drive,	Silver Sr	ring, MD 2	20901
ore,	E E E		20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 ☑	•	20b. Place of D	hisposition (Name of crematory or other p		Date	20c. Location - City	
III Page	ant: to		'4 □ Donation 5 □ Other (Speci			Heaven Cemet			Silver Spr	ing, Marylar
Baltimore,	Departing any inj		21. Signature of Funeral Service Lice	Jell 1	lere	Francis As 500 Unive	rsity Bl	s Funeral vd, W, Si	Home Inc	ng, Md 20901
PI	nysicia∩		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	pplications that cause on each	sed the death. Do no h line.	t enter the mode of d	ying, such as card	liac or respiratory a	rrest,	Approximate Interval Between Onset and Death
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cuted	hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events	· PE	RFORATI	ED COR	ONARY	ARTE	RY	Hours
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<b>587</b>	physic the b	dlcal		d	KUTAN	LOUS	CORONA	RY M	TERVENTI	an Itour
BOX	the attending phy	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		n 2 ☐ Fetal death t at time of death	3 □Ectopic pregnar 5 □ Other (specify)			23d. Date of d Month	lelivery Day Year
that the	igned by the a be detached i	y Ph	Part II. Other significant conditions	contributing to deat	h but not resulting in t	ne underlying cause	given in Part I.	23e. Did t	obacco use contribute	to the cause of death?
rds quires	been sign	ed by	ATTEMPTED	SALVAG	E CORO	NARY E	YPASS	1 🗆 `	Yes 2 ☐ No 3 ☐	Probably 4 Munknown
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The T	cate ha	Con						perfo 1 Yes	ormed? death? 2 No 1 ☐ Ye	
OT VITAI Physician: ⊺	certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			)there	eath (Check only c		
<b>≒</b> ₹	pis d	To .	1 Yes 2 No	28a. Date of I		ationt 3 DOA	The state of the s	A STATE OF THE PARTY OF THE PAR	dence 6 □Other (Sp how injury occurred	necify)
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DIVISION I or Attanding	Siractor in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of	Injury - At home, farn , etc. <i>(Specify)</i>	n, street, factory, offic	е	28f. Location (S City or Tox	Street and Number or I wn, State)	Pural Route Number,
Lospital	within 24 hours after death.  To tha Funaral Diractor: After t completely filled in by the tunera		29a. Certifier 1 Certifying P	hysician: To the be	ast of my knowledge,	death occurred at the	time, date and pla	ace, and due to the	cause(s) and manner date and place, and di	as stated.
the	thin 2.	Medical	one) 29b. Signature and title of certifier	and manner	stated.		nse number		29d. Date signed (Mor	
7	¥ + 8		200. Organization and an administration	7,0	101)		-			
	5		30. Name and address of person who	completed cause	of death (Item 23a) (T	ype, Print)	1000		MAY 6	0, 2005
			Thomas C.M.  31. Date filed (Month, Day, Year)	litano	MD 76	10 Carroll	Aver T	alcoma	MAY G	20912
	Sta Registr		MAY 09 2	NOT KINE	istrar's Signature	parte				

			For State Registrar	State of Ma	•	epartment of I Certificate of			ene. 005	17332
			Decedent's Name (First, Middle, Last	st)				2. Date of Death		3. Time of Death
	Physici /Medic		ROSE EUGENIE	STONEHOUSE				Month May	06 200	5 4:01A M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death		4c. County of De	eath
П			Washington Adve	ntist Hosp	ital		a Park		Montgo	mery
	Funeral Director		5. Social Security Number 6. S 579 • 38 • 4151	ex 7. Ag	e (In yrs. last birt 78	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) July 7,	rear)	Birthplace (State or Foreign Country)
			Usuaf Residence of Decedent		70			July /,	1920   0	anada
	nyland how	,	10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	e Ma	cto	Maryland   Montgome	ery	Silve	er Spring				1 Z¥Yes 2 □ No
	or 28	Dlre	10e. Street and Number	11 21 1 0	. 1	10f. Zip Code		100	g. Citizen of What	Country?
	s 238	eral	3521 Leisure Wor	· · · · · · · · · · · · · · · · · · ·		2090		ait. Van as Na	U.S.A.	nerican Indian,
21215-0036	be filed within 72 hours after death with the Maryland hal Hygiene. od other than "natural", or Itams 23a or 28a-f ahow event, If a Medical Examinar mast be incitified at	by Funeral Directo	11. Marital Status  1 □ Never Married 2 □ Married  3 ☼ Widowed 4 □ Divorced	12. Was Decedent Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cub  1 ☐ Yes 2 ☒ No		ecry fes of No- Rican, etc.)	Bfack, W	hite, etc.
o Q	72 ho	Completed	15. Decedent's Ed (Specify only highest gra		16a.	Decedent's Usual Occu (Give kind of work done	pation during most of worki	16	6b. Kind of Busines	ss/Industry
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2	led w lygier her th	Cor	17. Father's Name (First, Middle, Last)	4 year	S	Claims Adj	18. Mother's Name	/First Middle Ma	Insurance	e
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Ž	should id Me mark matic	70	19a. Informant's Name/Relationship (	Type, Print)	19b.	Mailing Address (Street				. Zip Code)
	od 2 sulth ar		David L. Stonehou	**		419 Alexand			·	
ē,	s 1 au if Hea itam		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·		Disposition (Name of y, crematory or other pla			c. Location - City	
Ë	Page nent o		1 ☐ Burial 2 ☑ Cremation 3 ☐  1 ☐ Donation 5 ☐ Other (Specif			incoln Cre		15/05 B	rentwood	Maryland
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Licer	1500		22. Name and Addre	ess of Facility	AT HOME	TNO	
<u> </u>	8958		Many A.	ece l	۷	HINES-RINA 11800 New	Hampshire	Ave, Si	lver Spri	ng, MD 20904
0.			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	i the death. Do n ne.	ot enter the mode of dy	ng, such as cardiac o	or respiratory arres	t,	Approximate Interval Between Onset and Death
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P.O.	The law requires that the death certi tte has been signed by the attending page 2 should be detached for use a	Physician/M	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown	time of death	5 ☐ Other (specify) _				,
	that ted by	/ Ph	Part II. Other significant conditions of	ontributing to death b	ut not resulting in	the underlying cause gi	ven in Part I.	23e. Did toba	cco use contribute	to the cause of death?
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S	aw require is been si 2 should t	Completed	Mitral Valve Ste	enosis				24a. Was an	24b. Were	autopsy findings available
Re	The la te ha: age 2	omp						autopsy performe	death	
ta		BeC	25. Was case referred to medical				26. Place of Death			200
<u>_</u>	Physic this ce al direc	To E	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 XInpatie	ent 2 ER/Out		her: 4 Nursing Hor	me 5 Residen	ce 6 □Other (S	pecify)
o D	Attending Physician: r death. sctor: After this certificator, by the funeral director.	ou:	27. Manner of Death  1 ☒ Naturaf 5 ☐ Pending	28a. Date of Inju (Month, Da		njury Wo		28d. Describe how	injury occurred	
Sic	r Attend er death ractor: A by the f	icat	2 Accident investigation 3 Suicide 6 Could not b		At home for		]Yes 2□No	196 Location /Stro	at and Alumbarar	Dum I Pauta Numbar
Division of Vital	= = C	ertification;	4  Homicide determined	building, et	c. (Specify)	m, street, factory, office		City or Town,		Rura I Route Number,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	O				, death occurred at the t				
	na Ho na Fui pletely	edical	(Check only 2 Medical Exar	niner: On the basis o	f examination and ated.	Vor investigation, in my	opinion, death occurr	ed at the time, date	e and place, and d	ue to the cause(s)
	To the To the To the Comp	M	29b. Signature and title of certifier	1		29c. Licen	-		J. Date signed (Mo	
	12		1 VV			D-5	7649	M	ay 6, 20	05
	( "		30. Name a address of person wh	pleted cause of c	leath (Item 23a) (	Type, Print)	o & NTCT #10	יז זו חחלי	a a b f m a t = :	n DC 20010
			Bryan Martin St				ec, NW, #Z	./UU-N, W	asningto	п, ре 20010
	Sta Registi		31. Date filed (Month, Day, Year)  MAY 10 2	2005 Steel	w S	perte				

			For State Registrar	State of M	aryland		rtment of H	lealth and l Death		giene Reg. No.	2005	17333
	0		Decedent's Name (First, Middle	e, Last)					2. Date of De.	ath		3. Time of Death
	Physicia		ETH	F 1	V.		THOMA	02001	Month MA X	Day	2005	- 1942 M
	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, or	Location of Death	4:071	4c.	County of Deat	
			CHESTER RIV	ER HOSPIT	TAL C	ENTER	CHE	STERI	TOWN		KEN	17
	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. la:	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	y, Year)	Co	nplace (State or Foreign untry)
	Director		218-16-9994 Usual Residence of Decedent	10 m 20X	80	Yrs.			6-4-	1924	<u>!</u>	MD
	land ow		10a. State 10b. County		10c. City,	Town or Loc	ation					10d. Inside City Limits
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	r 288	Director	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What Co	untry?
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	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)		14. Race - Ame Black, White	
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and	be file tal Hy d othe	Be C	17. Father's Name (First, Middle,	,			-	18. Mother's Nan			Surname)	
<u> </u>	should be and Menta marked umatic ev	2	Jefferson F						Butle:	_		
Mar	C1 00 00 00		19a. Informant's Name/Relations Ermyn Black/					and Number or Ru Meadow		-		
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Ē	mit. Pages partment of lortant: If it ortant: If it injury or o		1  Burial 2  □ Cremation 1  □ Donation 5  □ Other (5		Mt.	Oli	ve Ceme	tery 5/	7/2005	Wor	ton,	MD
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service	Samuel			Name and Addres					
	1		23a. Part . Enter the disease, o shock, or heart failure. List	r complications that cause only one cause on each	d the death.	Do not ente	er the mode of dyin	g, such as cardiad	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition				ETOACIA					Onset and Death HOURS
	/Medical Examiner		resulting in death)	Due to (or as	s a conseque	ence of):						
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	ed sit	niner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Cole to for at	в в сонвадие	янцы эту						
	xecut and al-trar	Examin	that initiated events resulting in death) Last	c Due to (or as	s a conseque	ence of):						
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ρ	tificat g phy as th	edi										
ŏ	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy	,		2	23d. Date of del	- ,
u	e deal	slcia	in the past 12 months? 1 □ Yes 2 ■ No	4☐Pregnant a			Other (specify)				Month	Day Year
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cord	req been shou	etec	DIFIC	7,00	, 5, 3				- 776		*	sopius some so
ě	as s	Completed							24a. Was autor perio		prior to death?	topsy findings available completion of cause of
<u>~</u>	n: The ficate h	e Co	05.11						1 ☐ Yes	2 No		2 No
VItal	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1 □ Yes 2 ☑ No	Hospital: 1 Inpati	iont 200	R/Outpatient	t 3□ DOA Oth	er: 4 Nursing H	th (Check only o		S DOther (Spe	n/h/l
0	g Phys or this oral di	<b>-</b>	27. Manner of Death	28a. Date of Inj	ury 2	28b. Time of	28c. Injur	y at	28d. Describe I			ily)
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DIVISION	r Atte er de: recto	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286, Place of It	njury - At hom	ne, farm, stre	eet, factory, office		28f. Location (3 City or Tox			ıral Route Number,
5	ital or aft raf Di											
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the bes Exeminer: On the basis and manner s	of examination	ledge, death on and/or inv	estigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To ti Withii To ti comp	Ň	29b. Signature and title of certific				29c. Licens	e number		29d. Dat	e signed (Mont)	n, Day, Year)
			> Secure >	muy			000	57509		57	14/05	
			30. Name and address of person			1		0	tertou	10	00-1 2	il In
	Sta	te.	31. Date filed (Month, Day, Year	0 5 2005	ar's Signatu	shire 100	ton Au	c Ciles	1C110CC	100	1100	1000
:	Registr		MAY	0 5 2005	S. Corre	A.	1984					

			For State Registrar	State of Maryla			rtment of F ificate of			gien Reg. N	4000	17334
			Decedent's Name (First, Middle, Last)						2. Date of De. Month	ath	ay Year	3. Time of Death
	Physicia /Medic		Frank Calvin 7	lappen, J	r.				5-	5	2005	2.01 PM
	Examin		4a. Facility Name (If not institution, give stre CIVISTA MEDICAL				4b. City, Town, o				c. County of Death	
			5. Social Security Number 6. Sex	7. Age (In y	re last hirth	adau)	LA PLA	TA, MA	e I o Data -4 Dia	45-	CHARLES	long (Chato or Farrier
F.	Funeral Director			2□F 62		rs.	Months Days	Hours Min	Sept.	Year	1942 Te	lace (State or Foreign try) EXAS
3	ъ		Usual Residence of Decedent						Jopes.			
J.	anylar show	_	10a. State 10b. County		City, Town						10	0d. Inside City Limits 1 ☐ Yes 2 🕅 No
6	28a-f	ecto	Maryland Charles	<b>;</b>	India	an	r			10. 0		
એ	with t	2	10e. Street and Number 5383 Emma Lane				10f. Zip Code 2064	n			citizen of What Coun	ıry :
3	death with the Maryland ms 23a or 28a-f show	Funeral Director	11. Marital Status 12.	Was Decedent Ever in	n U.S.	13. W			(Specify Yes or No orto Rican, etc.)		.S.A.	
17.4 altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, it a Modical Examitive mather milling at once.	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  ★□ Yes 2 □ No If Yes, Give Year or Dates:			Yes, specify Cuba ☐ Yes 2[XNo	an, Mexican, Pue Specify:	erto Rican, etc.)		Specify:White,	
5-0	72 ho	Completed	15. Decedent's Educati (Specify only highest grade co	on ompleted)	16a. [	Decede (Give ki	nt's Usual Occup ind of work done O NOT use retired	ation during most of w	orking	16b. I	Kind of Business/Ind	ustry
121	within ne.	dm		College (1-4or 5+)		iite. Do ale		1)		Dh	otograph	
70	filed v Hygie ther t		17. Father's Name (First, Middle, Last)		00	116	5	18. Mother's N	ame (First, Middle,		otograph n Sumame)	110
lan	ld be ental ked o	To Be	Frank C. Tappen,	Sr.				Lavor	nia Mae	Ak	ers	
ary	shou and M s mar umat		19a. Informant's Name/Relationship (Type,		19b.	Mailing	Address (Street				or Town, State, Zip	Code)
Σ	and 2 baith a n 27 is		Margaret Tappen	Wife				Lane, 1	Indian H	lea	d, Md. 2	0640
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem	oval from State	b. Place of I cemetery	Disposi , crema	tion (Name of atory or other place	e) May 7	Date 7 - 2005	20c. L	Location - City or To	wn, State
Ë	Pag tment tant: jury c		* 4 □ Donation 5 □ Other (Specify)	Me	etro						lexandri	a, Va.
Bal	permii Depar Impor any ir once.		21. Signature of Funeral Service Servi	M00	668	<sup>22</sup> ₩ 4	Name and Addre illiams 270 Hav	ss of Facility Funer ythorne	al Home	e, ] [nd:	P.A. ian Head	20640
			23a. Part1. Enter the disease, or complicat shock, or heart allure. List only one of	ions that daused the decause on each line.	eath. Do no	ot enter	the mode of dyin	g, such as cardi	ac or respiratory ar	rrest,		Approximate Interval Between Onset and Death
	Pnysician	1	Immediate Cause (Final disease or condition resulting in death)	150	hen	ije	Hear	+ D	iseay			Onset and Death
	/Medical Examiner		Tooling in doding	Due to (or as a cons	sequence of	f):						
	A	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury	Due to (or as a cons	sequence of	f):						
	outed od ransit	Examiner										
ó,	e exerian ar urial-t		resulting in death) Last	Due to (or as a cons	sequence of	f):						
68760,	ficate be executed physician and sthe burial-transit	edical	d									
	± D) of		IF FEMALE: 23c.	If yes, outcome of pred	олалсу						23d. Date of deliver	
Division of Vital Records, P.O. Box	leath certifi attending I ifor use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 F	etal death		ctopic pregnancy Other (specify)	1				Day Year
0	t the c by the achec	hysi	9 Unknown	9□ Unknown								
S,	res that the de signed by the a be detached f	by P	Part II. Other significant conditions contrib	outing to death but not r	resulting in	the und	lerlying cause give	en in Part I.	23e. Did to	obacco	use contribute to the	e cause of death?
ord	w require								1 🗆 ነ	Yes 2	2 □ No 3 □ Proba	ibly 4 🗷 Unknown
ec	e law r has t je 2 sh	Completed							24a. Was autop	OSV	prior to con	sy findings available apletion of cause of
<u> </u>	: The cate It	Col							1 Tes	rmed? 2 XN	o 1 Yes	2 No
× ×	hyaician: The la nis celtificate has I director, page 2	Be	25. Was case referred to medical examiner?	oital:			3C DOA Oth	a.m.	eath (Check only o			
of	Physic this stal di	. To	1 Yes 2 No	1 ☐ Inpatient 2  28a. Date of Injury (Month, Day Year)	-		28c. Injun	y at	Home 5 Resid		6 ☐Other (Specify	)
on	ttending Phy death. stor: After this the funeral c	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	r) Inj	jury	Wor	k? Yes 2 □ No		·	,	
<u>Vis</u>	ar dea ector	Iffice	all cuicide 6 Could not be	28e. Place of Injury - Al building, etc. (Spe	t home, farr	n, stree	et, factory, office		28f. Location (S City or Tox	Street a	and Number or Rural	Route Number,
Ö	ital or rs afte al Dir ed in	Cert		Duilding, etc. (3)					Only or ron	vii, Olai	10)	
	To the Hospital or Attending Physicien: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this ce litticate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	edical	29a. Certifier  (Check only one)  1 ☐ Certifying Physici  2 ☑ Medical Examiner	an: To the best of my k : On the basis of exam and manner stated.	knowledge, ination and	death o	occurred at the time stigation, in my o	ne, date and place pinion, death occ	ce, and due to the courred at the time,	cause(s date an	s) and manner as sta nd place, and due to	ited. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	- · · · · · · · · · · · · · · · · · · ·			29c. License	e number	7		ate signed (Month, E	
			yachia M. 7	ayour			D-5	088	5	5	16/20.	5.7
1	2 851		30. Name and address of person who comp	leted cause of death (II	Item 23a) (T	Гуре, Рг ۱	rint)	· m	206	46		
(L)	Sta	to.	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature L	سا	hall s			, ,		
	Registra		30. Name and address of person who comp 1 6 5 5 W; Me 31. Date filed (Month, Day, Year) MAY 1 0 20	US Johnson	מל ע	19						

		1 - State of Ma		artment of rtificate o		Mental Hygie	71115	17335
Physic	ian	Decedent's Name (First, Middle, Last)     DECEMBER   TEAM	1, 2,			2. Date of Death Month MAY 12, 2	Day Year	3. Time of Death
/Med Exami	ical	BETTY JEAN UBER  4a. Facility Name (If not institution, give street and number)		4b. City, Town	n, or Location of Dea		4c. County of Death	8:35 PM
Exam	illei	GARRETT COUNTY MEMORIAL H	OSPITAL	0AKL			GARRETT	
Funera Directo		282-30-9605 <sup>1□M 2X F</sup> 71	e (In yrs. last birthday) Yrs.	If Under 1 Ye Months Day			9. Birthp Cour	place (State or Foreign htry) WV
aryland show	_	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo				1	0d. Inside City Limits 1 X Yes 2 □ No
the Ma 28a-f	Directo	MD GARRETT  10e, Street and Number	OAKLA	10f. Zip Code	4	100	Citizen of What Cour	
h with 3a or	10	103 MASON STREET		215			JSA	,
ING 21215-0036  be filed within 72 hours after death with the Maryland tal Hygiene d other than "neture!, or Itams 23a or 28a-f show event, the Madical Examinar must be natified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced  12. Was Decedent Amed Forces?  1 Yes. Give	Jo I	Was Decedent of If Yes, specify C 1 ☐ Yes 2 ☑ 1	of Hispanic Origin? (Suban, Mexican, Puel No <i>Specify:</i>	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: WH]	etc.
1215-003 within 72 hours and. then "neturel; one Medical Example.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5	(Give	dent's Usual Oci kind of work do DO NOT use ref [EMAKER	ne during most of wo	orking 16b	. Kind of Business/Inc	
E a la b s	To Be Co	17. Father's Name (First, Middle, Last) HOMER NELSON NEFF, SR.				me (First, Middle, Maid	den Surname)	
re, Maryla s 1 and 2 should f Health and Man item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)  BONNIE MARTENEY - DAUGHTE		ng Address (Stre VERLOOK		ural Route Number, Cit OAKLAND, MI		Code)
altimore, rmit. Pages 1 ar partment of Hea portent: If item y injury or othe		20a. Method of Disposition 1 □ Burial 2 ☑Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, cre. OMEGA CR	matory or other p	place)	Date 20c	. Location - City or To	
Baltimor parmit. Pages Department of Importent: If it any injury or o		'4 □Donation 5 □Other (Specify)  21. Signature of Juneral Providence	2:	2. Name and Ad	dress of Facility	P.O. BO		
Physician /Medical		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lind limmediate Cause (Final disease or condition resulting in death)  Due to (or as	the death. Do not entered to the death. Do not entered to the death. Do not entered to the death.	ter the mode of c	tying, such as cardia	c or respiratory arrest,	reul	Approximate Interval Between Onset and Death
ate be exacutad Experience of the burial-transit experience of the	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or escape to the cause of the cause) Due to (or escape to the cause of t	a consequence of):	Lear Lefon	t gon Viali	line		( wonth
I HECOTGS, P.O. BOX 68/60,  The law requires that the death certificate be exacuted at has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregna Other (specify)			23d. Date of delive Month	ery Day Year
dS, P.	þ	Part II. Other significant conditions contributing to death b	ut not resulting in the u	nderlying cause	given in Part I.		co use contribute to the	
Records, The law requires to ate has been signed agge 2 should be considered.	Completed					24a. Was an autopsy performed 1  Yes 2  ፟	prior to cor death?	psy findings available impletion of cause of
of Vital Re Physician: The k rithis certiticate ha	Be	25. Was case referred to medical examiner?				ath (Check only one)		
ding After	tlon; To	1 Tyes 2 No Hospital: 1X Inpatie  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		f 28c. Ir	Other: 4 Nursing I njury at Vork? Yes 2 No	10me 5 Residence 28d. Describe how in		<i>(</i> )
Division  To the Hospital or Attend within 24 hours after death To tha Funerel Diractor: /	Certification:	2 Could not be	ury - At home, farm, sti c. (Specify)	reet, factory, office	ce	28f. Location (Street City or Town, St	and Number or Rura ate)	l Route Number,
To the Hospital or within 24 hours after To the Funerel Dir completely filled in	Medical C	29a. Certifier (Check only one)  1 X Certifying Physicien: To the best 2 Medical Exeminer: On the basis of and manner sta	examination and/or in	h occurred at the vestigation, in m	a time, date and plac by opinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
To the within To the Comp	W	29b. Signature and title of certifier	ans	29c. Lice	ense number	801 29d.	Date signed (Month,	Day, Year)
3		30. Name and address of person who completed cause of d		Print)	67 (	Ye Look	land mi	2711
Si Regis	tate trar	31. Date filed (Month, Day, Year)  MAY 1 6 2005	ar's Signature	selles	X11,761,	IE GOOR	19141 151	-17 70

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

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hysician /Medical xaminer	Decedent's Name (First, Middle, L     Teofila Talaver								Date of Dea	46-		
/Medical		*** 1						-	Month	atn Day	y Year	3. Time of D
		ra Vidanes	3					N	hy 8,	200		3:12
	4a. Facility Name (If not institution, g		per)				Location of	of Death		4c.	County of Oe	ath
	Adventist Bradford (		Ama (Internal	la at biotholas I	Cli If Under	nton	If Under	24 Hre o	Data of Riv		rince Ge	
neral ector	231-21-0358	Sex 7. 1□M 2∏F	Age (In yrs. 95		Months	Days	Hours	Min.	ne 13,	y, Year)		irthplace (State or i Country) lippines
A ==	Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City
Į į	Maryland Prince Geo	roe's	For	t Washir	naton							1 ☐ Yes 2
iner must be notified	10e. Street and Number	200 5	101	c nacini	10f. Zip	Code				10g. Cit	izen of What C	Country?
Q E	6600 St. Ignatius Dr	ive #102			20	0744				U.S.	Α.	
ner ner	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.		Was Dece	dent of Hi	spanic Ori	igin? (Speci	fy Yes or No-		14. Race - Am Black, Wh	
를교	1 Never Married 2 Married				1 ☐ Yes		Specify:		33.1, 313.7		Specify:	
d by	3€ Widowed 4 □ Divorced	Year or Date	es:									Filipino
Important: It tem 27 te marked other then "natural, or tema 23a of 28a-1 enow any injury or other traumatic event, the Modeal Evanirar must be notified at once.  To Be Completed by Funeral Director	15. Decedent's (Specify only highest g			16a. Dece	dent's Usu <i>kind of wo</i> DO NOT u	rk done a	turing mos	st of working	,	16b. Ki	ind of Busines	s/Industry
la la	Elementary/Secondary (0-12)	College (1-4	lor 5+)		emaker	30 /01/100,	,			Δt	: Home	
e C	17. Father's Name (First, Middle, Las	st)		130112			18. Mothe	er's Name (	First, Middle,			
To B	Nicomedes Talavera						Juli	ia Casu	calan			
T T	19a. Informant's Name/Relationship			19b. Mailir	ng Address	s (Street a				r, City o	r Town, State,	Zip Code) #10
tra	Victoria McMahon /	Daughter									Marylar	
othe	20a. Method of Disposition	_	1 0	Place of Dispo emetery, crer	sition (Nai	me of	e)	Dat	te	20c. Lo	ocation - City o	or Town, State
ry or	1 ☑ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec			Marys (				May 11,	2005	Clint	on, Mary	and
in ei	21. Signature of Funeral Service Lic	ensee		22	2. Name ar	nd Addres	s of Facilit	ty Coora				Home P.A.
# B	Kall. K.	clas (1)		61	.60 Oxo	on Hil	1 Road				and 2074	
	23a. ant. Enter the disease, ir co shirt, or heart failure. List on	mplications that cau	sed the death									Approximate Interval Between
the burial-transit apply the burial-transit about the burial-transit ab	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	r as a consequ	uence of):							an Cless	
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by be	Part II. Other significant conditions	contributing to dea	th but not resu	ulting in the u	nderlying o	ause give	n in Part I.			bacco u		to the cause of dea
should t									24a. Was	20	24h Were	autoney findings av
director, page 2 should									autop perfor	sy	prior to death? 1 \( \text{Ye}	
Be Be	25. Was case referred to medical examiner?	Hospital				04.		of Death (	Check only o	ne)		
a F	1 Yes 2XXNo	Hospital:	- I	ER/Outpatier			4 XXVI				6 □Other (Sp	ecify)
funeral tlon: T	27. Manner of Death 1 XX Natural 5 ☐ Pending		Day Year)	28b. Time of Injury	M	28c. Injury Work	at (? /es 2 □ i		d. Describe h	iow injur	у оссиней	
ed in by the tunera Certification;	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of	f Injury - At ho j, etc. <i>(Specif</i> )	ome, farm, str y)			165 2 🗆		f. Location (S City or Tow			Rural Route Numbe
completely tilled in by the		Physician: To the baseminer: On the baseminer	is of examinal									
	29b. Signature and title of certifier				29	crticense	number			29d. Dat	e signed (Mor	nth, Day, Year)
W						Pľ	743	/		(	19/0	00
Comp												
Comp	30. Name and address of parson wh	o completed cause	of death (Item	1 23a) (Type,	Print)		4 4 10	/	1		1	
completely filled in by the tuner  Medical Certification:	30 Name and address of Ason wh	completed cause	of death (Item	1 23a) (Type,	Print)	w/1	11	103	FT. V.	100	my/o	WM) 2

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1 - For State Registrer	State of Ma	aryland / Depa		of Health a of Death	and Me		ene 200	15 17338
	Physici /Medio		1. Decedent's Name (First, Middle, Last  James Elmer	Vaugha	n			2	. Date of Death Month May		3. Time of Death 9:30 A M
	Examir		4a. Facility Name (If not institution, give 6001 Muncaster Mi 5. Social Security Number 6. Se	11 Road-C	asey House		wn, or Location of ckville fear   If Under 2		Date of Birth	4c. County of I	omery
Ŀ	Funeral Director			M 2□F /. Age	91 Yrs.		ays Hours	Min.	Month, Day, June 20	Year) 1913	Birthplace (State or Foreign Country) Virginia
	the Maryland 28a-f show notified at	rector	10a. State         10b. County           Md •         Montgo           10e. Street and Number	mery	10c. City, Town or Lo				10	lg. Citizen of Wha	10d. Inside City Limits 1 🗆 Yes 2 🖼 🗖 o
9003	is 1 and 2 should be filed within 72 hours after deeth with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or Items 23s or 28a-f show other traumatic event, the Madical Eventinal must be notified at	d by Funeral Director	12811 Flack Stree  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	lo	Was Decedent f Yes, specify 1 ☐ Yes 2 ☑	209 of Hispanic Oric Cuban, Mexican No Specify:			United	
Maryland 21215-0036	ed within 72 h ygiene. ier than "nati	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation (e <i>completed)</i> College (1-4or 5	+) (Give	dent's Usual O kind of work d DO NOT use re SS Glaz	lone during most etired) ier			6b. Kind of Busin	,
ryland	12 should be filed within h and Mental Hygiene. 7 Is marked other than "raumatic event, the Mas	To Be (	17. Father's Name (First, Middle, Last)  James Patrick	Vaughar		Add /04	Ju	1ie	Cather		esser
	1 and 2 st Health and em 27 Is r ither traur		19a. Informant's Name/Relationship (T) Mimah J. Vaughan  20a. Method of Disposition	· .	1282 20b. Place of Dispo	L1 F1ac	k Stree		lver Sp	City or Town, Sta ring, Md 0c. Location - City	20906
Baltimore,	Page nent c		1 ☐ Burial 2 ☐ Cremation 3 ☐ If 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Licens		remetery, crer Parklawn	natory or other Cemete	rplace)		/2005	Rockvi1	
Ba	permit. Departr Imports eny inje		Druvief of 23a. Part1. Enter the disease, or comp	Barlo	er	P. O.		38, L	aytonsv	ille, Md	20882 Approximate
	Physician /Medical Examiner	Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each lin  RECU  Due to (or as a	e.  JRRENT LYMI a consequence of):  a consequence of):				oop.a.or, and		Interval Between Onset and Death
.O. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical Exa	resulting in death) Last	Due to (or as a d	2 ☐ Fetal death 3 ☐	Ectopic pregn				23d. Date of Month	delivery Day Year
0	quires that the signed by ald be detact	by	Part II. Other significant conditions co	ntributing to death bu	it not resulting in the ui	nderlying cause	e given in Part I.		23e. Did toba		te to the cause of death?
Vital Records,		Completed							24a. Was an autopsy perform, 1 Yes 2	prior	
o	attending Physicien: 1 death. ctor: After this certificat y the funeral director, p	ation; To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatier  28a. Date of Injury (Month, Day	nt 2 ER/Outpatien  y Year)  28b. Time of Injury	28c.	Other	rsing Home			Specify) Hospice
Division	Hospitel or Attending 14 hours after death. Funeral Director: Afte tely filled in by the fune	I Certification:	3 Suicide 6 Could not be determined	building, etc					City or Town,	State)	r Rural Route Number,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	(Check only one)  29b. Signature and title Century	ner: On the basis of and manner sta	f my knowledge, death examination and/or inv ted.	estigation, in r	ne time, date and my opinion, deati	h occurred	at the time, dat	e and place, and	due to the cause(s)
	3		30. Name and address of person who co				D412	248	15	5/05	105
	Sta Registr		CHARLES HARRISON,  31. Date filed (Month, Day, Year)  MAY 0 9 200	Registra	1355 PICC	ARD DR.	, ROCK	VILLE	, MD.	20850	

			For State	State of Ma	-	epartment of h		-	200	7 1700
			Registrar  1. Decedent's Name (First, Middle, L	ast)		Scrincate of	Dealit	2. Date of De	Reg. No. 💪 🔾 🔘 .	3. Time of Death
	Physici /Medic		JAMES D	WIL	SON			Month 05	Day Year 07 2005	9.45 AM
	Examin		4a. Facility Name (If not institution, gi			4b. City, Town, o	or Location of Dea	ith	4c. County of Dea	th
		7	Howard County Ge				mbia		Howard	
	Funeral Director		,	Sex 7. Age 1XIM 2□F	in yrs. last birtl 78 Y	nday) If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bird Month, Da	<sup>th</sup> Year) 9. Bir 4, 1926 Pe	thplace (State or Foreign buntry) ennsylvania
-			209 12 8661 Usual Residence of Decedent		70			ouic 1	1, 1, 2, 1,	ambyr varia
	arylan ahow	<u>.</u>	10a. State 10b. County		10c. City, Town					10d. Inside City Limits 1 ☐ Yes 2 🐴 No
	Ba-f	Director	MD Howard	<u>a</u>	Colu					
	with t	ū	10e. Street and Number 11460 Little Pat	uvent Park	7av #508	10f. Zip Code 2104	.4		10g. Citizen of What Co	•
	death with the Maryland ms 23a or 28a-f ahow rmust be rollfied at	Funeral	11. Marital Status	12. Was Decedent B		13. Was Decedent of H		Specify Yes or No	- 14. Race - Ame	erican Indian,
٥	or ite		1 Never Married 2 Married	Armed Forces?  1 X Yes 2 N If Yes, Give	lo	If Yes, specify Cub 1 ☐ Yes 2X No		rto Rican, etc.)	0 "	
3-003 <i>a</i>	hours ural',	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates: 1	.945-55					Lack
<u>ი</u>	n 72 "nat	Completed	15. Decedent's I (Specify only highest g	rade completed)		Decedent's Usual Occup Give kind of work done life. DO NOT use retire	during most of wo	orking	16b. Kind of Business	Andustry
7	d withing jiene.	omp	Elementary/Secondary (0-12)	College (1-4or 5		pervisory S	upply Mg	mt Spec.	Federal (	Soverment
ana	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or items 23a or 28a-1 ahow avant, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Las	it)		·			Maiden Surname)	
ya		To	James Wilson				Susan J			01011
Mar	s 1 and 2 should f Health and Mer itam 27 is marke othar traumatic		19a. Informant's Name/Relationship Teresa Merlau/Dat						er, City or Town, State,	
ย์	is 1 and in the structure it am 27 other tr		20a. Method of Disposition	igner	20b. Place of	Disposition (Name of		Date	20c. Location - City or	
Saitimor	permit. Pages Department of H Important: If ite any injury or of		1 ☐ Burial 2 🛣 Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			crematory or other pla Crematory		-2005	Catonsvill	e, MD
	permit. f Departm Importar any injur		21. Signature of Funeral Service Lice		M01044	_	ess of Facility Ha	rry H. W	itzke's Fan	ily FH Inc.
n	permi Depar Impor any ir		John Gla	, - with		4112 Old	Columbia	Pike El	licott City	, MD 21043
			23a. Part1. Enter the disease, or con shock, or heart failure. List onl	nplications that caused y one cause on each lir	the death. Do no				rrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Bc	acten	al In	nemor	119		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence o	f):				
h		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as :	a consequence o	r):				
	outed id ansit	Examiner	that initiated events	C						
Š	e exection artical-ti	Exc	resulting in death) Last	Due to (or as	a consequence o	r):				
9/60	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the buriat-transit	dlcal	•	d						
O X	certific iding p		IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date of de	liven
DOX	death atter	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	у		Month	Day Year
į.	t the c by the	hys	9 Unknown	9□ Unknown						
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necoras,	e law has b	Completed						24a. Was autop		utopsy findings available completion of cause of
	n: The icate r, pag							1 ☐ Yes	ZENo 1 ☐ Yes	2 □ No
VII	/sician: The law s certificate has b director, page 2 s	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	nt 2 ER/Out	patient 3 DOA Oth	200	eath (Check only o	ne) dence 6 □Other <i>(Spe</i>	o(b.)
0	g Phy er this eral d	<b> -</b>	27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Ti	me of 28c. Injur	ry at		now injury occurred	cny)
0	andin ath. or: Aft	atlo	☐⊠Natural 5 ☐ Pending 2 ☐ Accident investigati	on	7 (647)	ury Wo M 1⊟	Yes 2□No			
DIVISION OF	ter de irecto n by ti	ertification;	3 Suicide 6 Could not 4 Homicide determine		ury - At home, fan c. (Specify)	m, street, factory, office		28f. Location (5 City or Tox	Street and Number or R vn, State)	ural Route Number,
ב	pital c	O	On Cariffin a Physioletica F							
	To tha Hospital or Attending Physician: within 24 hours after death.  To tha Funaral Director: After this certifica completely filled in by the funeral director, is	edical	29a. Certifier 1 CCertifying F (Check only one) 2 Medical Exa	Physician: To the best of aminer: On the basis of and manner sta	examination and	oeath occurred at the till for investigation, in my o	me, date and plac opinion, death occ	e, and due to the curred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Mont	h. Day, Year)
			1 / 1			D43	3725		5/7/05	
0	<del>}</del>		30. Name and address of person who	completed cause of de	eath (Item 23a) (	Type, Print)	4.7	0	M	21221
V	5.555		JARIQ MAH 31. Date filed (Month, Day, Year)	MOUD 2	UI-109	15 ACICICI	ver ive	eck Ilua	ack 15alt	more
	Sta Registr		MAY 1 0	completed cause of de hours of de hours are de la cause of de hours are de la cause of de hours are de hours	a soignature	Sperker				
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			State of M	laryland / Depa			-	neonor	17010
		•	1 - State Registrar	Ce	rtificate of D	Death	Reg. I	No. CUUJ	1/340
			Decedent's Name (First, Middle, Last)			2.	Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Helen Wynes			^	~	2005	1830 M
	Examin		4a. Facility Name (If not institution, give street and number	# 4-14	4b. City, Town, or		1	4c. County of Death	,
			10117 Prince Place	754	upper			111100	eorge's
	Funeral		1 □ M 2 □ XF	ge (In yrs. last birthday) : •	Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Yea September	1951 9. Birthp	lace (State or Foreign
	Director		216-64-2210 Usual Residence of Decedent	Yrs.			ерсешье	L 29 Wasi	ington,DC
	/land		10a. State 10b. County	10c. City, Town or Lo	ocation			1	0d. Inside City Limits
	Man a-f sh	to	MD Prince George's	Upper Ma	arlboro				1X Yes 2 ☐ No
	th the	Funeral Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cour	ntry?
	23e	al	10117 Prince Place # 404		207			U.S.A.	
	tems	nue	11. Marital Status 12. Was Deceden Armed Forces		Was Decedent of His If Yes, specify Cubar	spanic Origin? (Specif n, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Americ Black, White,	
36	hours after death with the Maryland turel', or Items 23e or 28a-f show al Examinar rust be nicitied at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗷  3 ☐ Widowed 4 ☐ XDivorced Year or Dates:		1 ☐ Yes 2 🗷 No	Specify:		Specify:	1.
8	thou sture	ed	15. Decedent's Education	16a, Dece	dent's Usual Occupa	ition	16b	. Kind of Business/Ind	ack dustry
712	within 72 ene. then "nai	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or	life.	e kind of work done d DO NOT use retired;	furing most of working )			
21	giene griene er the	Completed	12th		dministra			Private	
nd	be filed ital Hygid od other event, II	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (F Hilda M.			
yla	should be nd Mental marked c	<sup>2</sup>	Richard A. Brooks Sr.						
Maryland 21215-0036	0 0 0 0		19a. Informant's Name/Relationship (Type, Print)  Charlotte Smith, Sister			and Number or Rural R			
	1 and 2 Health em 27 other tr		20a, Method of Disposition	20b. Place of Dispo	osition (Name of	Date		Location - City or To	
Baltimore,	eg: = 5		1 XBurial 2 □ Cremation 3 □ Removal from State  4 □ Donation _5 □ Other (Specify)	Harmony	matory`or other place	5/11/0	)5 T.:	andover,Ma	rvland
Ē	permit, Pa Departmer Importent any injury		21. Si parure of Fa eral Service Licensee		2. Name and Addres			ins Funera	-
Ba	permit, Departr Imports any inji		A SOLD ALL	7	7474 Lando	ver Road I			
	- 37		23a. Part 1: Sote the disease, or complications that cause shock, or heart failure. List only one cause on each						Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	oscleration	Condra	varcular	Heart	- Diseas	Onset and Death
	/Medical		resulting in death)  Due to (or a	s a consequence of):					
	Examiner	_	Sequentially list conditions, if any, leading to immediate b. Due to (or a						
	ed sit	Examiner	if any, leading to immediate cause, Enter underlying Cause (Disease or injury	s a consequence of):				-	
	xecut and	xan	that initiated events c.	s a consequence of):					
760,	icate be executed physician and s the burial-transit	caiE							
68									
Вох	leath certificat attending phy I for use as the	In/M	IF FEMALE: 23c. If yes, outcom		□Ectopic pregnancy			23d. Date of delive	
	death	sicia	in the past 12 months?  1 Yes 2 No 4 Pregnant		Other (specify)			Month	Day Year
P.0	that the dened by the a	Physician/Med	9 Unknown	h		- i- B-41	22a Did tahaar	co use contribute to the	no cause of death?
	8 50	by	Part II. Other significant conditions contributing to death  Dra Detes	but not resulting in the t	underlying cause give	en in Part I.	1 ☐ Yes		pably 4 □Unknown
Vital Records,	w require been si should l	Completed	Die Deles			<del></del>			
3ec	e law has t	ig m					24a. Was an autopsy performed	prior to co	psy findings available mpletion of cause of
a							1 ☐ Yes 2 ☐	No 1 ☐ Yes	2□ No
Ζ		o Be	25. Was case referred to medical examiner?  1 Pres 2 No Hospital: 1 Inpa	tient 2 ER/Outpatie	ont 3□ DOA Othe	26. Place of Death ((		6 □Other (Specif	iv)
of	Phys arthis aral di	H-	27. Manner of Death 28a. Date of In	jury 28b. Time of	of 28c. Injury	at 280	d. Describe how in		77
ion	Attending For death.  ector: After by the funer	atio	1 Natural 5 Pending (Month, C 2 Accident investigation	Day Year) Injury	M 1 🗆 '	Yes 2 □ No			
Division	I or Attendi after death. Director: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of I building.	njury - At home, farm, st etc. (Specify)	treet, factory, office	281	Location (Street City or Town, St	and Number or Rura	I Route Number,
Ö	rs afte el Dir	Cer							
	Hosp 4 hou Funer	icai	29a. Certifier 1 Certifying Physician: To the best Check only 2 Medical Examiner: On the basis	of examination and/or in					
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	Medicai	one) and manner : 29b. Signature and title of certifier	нател.	29c. License	number	29d.	Date signed (Month,	Day, Year)
	1 × 1 × 8		Alada Ale	to so					
Λ	(10)		30. Name and address of person who co. pleted cause of	death (Item 23a) (Type	, Print)			7 7	
K	(1)		Sulvador Sylvester 30	I Hospit	tal Dri	ng Che	vely	MUATY 14	va
	Sta	ate	31. Date filed (Month, Day, Year)	strar's Signature		7			
	Regist	raŗ	MAY 1 0 2005 Been	U AF BOO	wee.				

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

**ORIGINAL** 

		Registrar     Decedent's Name (First, Middle, L.)	ast)		Cei	rtificat	e or t	Jeaur		2. Date of		. No.		3. Time of Death
hysici/ Medic		Arthur D.	Wright 1	II						Month 5		Day O't	Year 1005	600PM
Examin		4a. Facility Name (If not institution, gi		-)				Location	of Death			4c. County		
		Laurel Regional			1-16-4-3	Lau If Under	re1	If Under	24 Hrc	0.0	D:-#-	Anne	,	
uneral rector		039-36-9150	Sex 7. A 1.25 M 2.□ F	ge (in yrs. 46	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of (Month, June	Dav. Y	1958	Co	place (State or Foreig intry) deIsland
A T		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation								10d. Inside City Limits
d sh	tor	MD Prince	reorge ! c	R	eltsvi	116								1XTYes 2 ☐ No
128	lrec	10e. Street and Number	SCOIEC 3		CILOVI	10f. Zip	Code				10g	. Citizen of	What Co	untry?
23e c	alD	11332 Broken Bo	w Court			207	705					U.S.	Α.	
Important: If item 27 Ia marked other then "natural", or Items 23e or 28e-f show eny injury or other traumatic avent, the Madical Examinatingst be nutified at QDCs.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1  Yes 2 If Yes, Give Year or Dates:	? ]No		Was Deced f Yes, spec 1 ☐ Yes		spanic Or n, Mexica Specify:		ecify Yes or Rican, etc.	No-		ck, White	rican Indian, b, etc. Black
natur IIC	eted	15. Decedent's 8 (Specify only highest g			16a. Dece	kind of wo	rk done d	durina mos	st of work	ina	16	b. Kind of B	lusiness/l	ndustry
" hen "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT u	se retired	)				Priva	.+.	
nt, in	S	17. Father's Name (First, Middle, Las	5+			Atto	rney	18 Moth	er's Nam	e (First Mir	idle Ma	iden Sumar		
ed of	Be C	Arthur D. Wrigh								a Cor		idon obman	.,,,	
mark	2	19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a	and Numb	er or Rur	al Route Nu	mber, C	city or Town,	, State, Z	ip Code)
27 la rrtrau		Sharon Wright/Wi	fe		1133	2 Bro	ken	Bow (	Court	Belt	svi	lle,Ma	ary1a	ind 20705
item othe		20a. Method of Disposition		1 -	Place of Dispo	sition (Nar	ne of other plac	e)		Date		c. Location	- City or	Town, State
int: If iry or		1 Table 2 □ Cremation 3 1 Table 2 □ Cremation 3 1 Table 2 □ Cremation 3		9	rmony l			(	05-09	9-2005	Lá	andove	r,Ma	ryland
Importa eny inju once.		21. Signature of Funeral Service Lice	hall		22	2. Name ar	d Addres	over	Road	Land	ovei	, Mar		1 Home d 20785
sician		23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition	mplications that cause y one cause on each a. GASTRI		h. Do not ent									Approximate Interval Between Onset and Death 3 MONTE
edical iminer	er	resulting in death)  Sequentially list conditions, if any, leading to immediate	Due to (or a	M	ALMUT	TRITI	DIL	^						2 MONTH
physician and s the burial-transit	sal Examiner	causée. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. LARGE Due to (or a		EURA uence of):	LE	FFI	iSIE	1	- B.	CAT	EILA	<u> </u>	3 MONITH
ied by the attending phy detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	Ideath 3	Ectopic pa							ate of deli	very Day Year
D 9	by	Part II. Other significant conditions	contributing to death	but not res	utting in the u	nderlying c	ause give	en in Part I	l.		id toba			the cause of death?
cate has been si , page 2 should	Completed									a	Vas an utopsy erforme es 2)	d?	prior to c death?	opsy findings available ompletion of cause of 2 No N A
certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	200		h (Check or				
After this funeral di	on: To	1 ☐ Yes 2 🔀 No  27. Manner of Death  1 🛣 Natural 5 ☐ Pending	1 ☐ Inpat 28a. Date of In (Month, D	jury	ER/Outpatier 28b. Time of Injury	1 2	28c. Injun Worl	/ at c?				injury occur		ify)
Diractor: in by the	ertification;	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of I	njury - At h etc. <i>(Specit</i>	ome, farm, str (y)	M reet, factor		Yes 2□	No		on (Stree Town, S		ber or Ru	ral Route Number,
e Funeral I	edical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex-	Physician: To the bes aminer: On the basis and manners	of examina	owledge, deat ation and/or in	h occurred vestigation	at the tin	ne, date ar pinion, dea	nd place, ath occur	and due to red at the tir	the caus	se(s) and m and place,	anner as and due	stated. to the cause(s)
To the I	Me	29b. Signature and title of certifier				290	c. License	number			29d	. Date signe	ed (Month	, Day, Year)
- 0		TEAD	Sun	N	OA	0	100 4	-10.	39			5-3	5-0	5
( _ )														

			1 - State Registrar	State of I	Marylan	•	artmen tificat			and M		eg. No.	05	173	43
	Physicia		Decedent's Name (First, Middle, Last)  JOSEPHT	NE WELS	H						2. Date of Deat Month MAY	Day 06	2005	3. Time of 5:45	Death P M
	/Medic Examin		4a. Facility Name (If not institution, give s. 7 LEWIS DRIVE				4b. City,		Location o				nty of Death	1	
Ì	Funeral Director		110 20 1012	M 21XF	Age (In yrs. 85	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Jan 2,	1920	Cour	lace (State o try) irgini	-
	e Maryland Ba-f show	ctor	Usual Residence of Decedent  10a. State  Maryland  Harfo	rd	10c. City	y, Town or Lo	Aber	deen	1					0d. Inside Cit	
	with the	Directo	10e. Street and Number 7 Lewis Drive				10f. Zip		1001		1	-	of What Cour ited S		
036	filed within 72 hours after death with the Maryland Hygione. ther then "natural", or Items 23e or 28e-f show ant, Ite Macilcal Examiner must be notified at	by Funeral	11. Marital Status 1  1 Never Married 2 Married 3 Midowed 4 Divorced	2. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	s? X No	i	Was Deced f Yes, spec 1 ☐ Yes		spanic Ori n, Mexican Specify:	gin? (Spe	ecify Yes or No- Rican, etc.)	E	Race - Americ Black, White, cify: Bla	etc.	
9500-61212	vithin 72 ho ne. hen "natur e Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		or 5+)	16a. Deced (Give life.	kind of wo DO NOT u	rk done d se retired)	uring mos		ing	-	Business/Ind		
Z D	be filed v stal Hygie sd other t event, to	0	17. Father's Name (First, Middle, Last)	5+		ACIILLI	ISCIC	ICTVE			e (First, Middle, I			eric	
Maryland		To B	William Gordon								Lockett				
	permit. Pages 1 and 2 should b Department of Headib and Mente Importent: If item 27 is marked any injury or other traumatic a <u>once</u> .		19a. Informant's Name/Relationship (Type Ronald Welsh / son 20a. Method of Disposition	oe, Print)	20h P		Вох	938,		re de	al Route Number e Grace, Date	Mary		1078	
305	Pages 1 nent of H ant: If ite ary or ot		1 Magnetical 2 □ Cremation 3 □Re  1 Donation 5 □ Other (Specify)	emoval from Sta	ıte C	ion Un	natory`or o	ther place			13/05		leen, N		nd
Baltimore,	permit. I Departm Importer any injur		21. Signature of Funeral Service License	in the							al Home, Havre				
7,097	certificate be executed ding physician and manage as the burial-transit	icai Examiner	23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	h line.	NARY uence of): uence of):			,					Interval Bett	veen Death
O. Box 68	death certific e attending p id for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	3c. If yes, outco 1□Live birtl 4□Pregnan 9□Unknow	n 2∏Feta tat time of d	ıl death 3 [	Ectopic p						Date of delive		'ear
ds, P.	w requires that I been signed by should be deta	by	Part II. Other significant conditions con	tributing to deat	h but not res	ulting in the u	nderlying o	ause give	en in Part I		23e. Did tol	~	ontribute to the	ne cause of d	
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Division of Vital	Jing Ph J. After th funeral	tlon; To Be	27. Manner of Death 1. Natural 5 Pending	lospital: 1 Inp 28a. Date of (Month,		ER/Outpatier 28b. Time o Injury		8c. Injury Work	at □ Nu	ırsing Ho	h (Check only on ome 5 Reside 28d. Describe ho	ence 6 🗆 (	Other (Specificurred	y)	
Divisi	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		Injury - At he, etc. (Specif	ome, farm, str fy)	reet, factor	y, office			28f. Location (Si City or Town		imber or Rura	l Route Num	ber,
	To the Hospitel or within 24 hours after To the Funerel Direction completely filled in I	edical	29a. Certifier Check only one) Certifying Phys	sicien: To the base ner: On the base and manne	is of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim	ne, date ar pinion, dea	nd place, ith occur	and due to the cored at the time, d	ause(s) and ato and plac	manner as s ce, and due to	ated. the cause(s	
	To t. withi To tl	×	29b. Signature and talle or certifier	- W			1	C. License	1 00 1	16			gned (Month,		5
	5		30. Name and address of person who are	moleted cause	560/L	n 23a) (Type,	Print)	BIVE	2 Sin	ite	2087 1	37/Time	RE M	いっとい	_39
	Sta Regist		31. Date filed (Month, Day, Year)  MAY 1 0 20	105	istrars Signa	ature	book	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MAY 17 **Physician** 2005 0305 М Marie Weimer /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY MEMORIAL HOSPITAL CUMBERLAND If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🙀 F Yrs. Director 82 212-38-6163 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if flem 27 is marked other than "natural", or the any injury or other trainments. 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Fulton Warfordsburg 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 2891 Buck Valley Road 17267 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: Specify 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 8 Homemaker Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alvie Lewis Sowers Ruhe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley M. Ray / daughter 2891 Buck Valley Road, Warfordsburg, PA 17267 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 5 Other (Specify) Restlawn Mem. Gardens 05/19/2005 LaVale. Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, Maryland 21502 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between shock, or heart failure. 5 TEARS ath Immediate Cause (Final disease or condition resulting in death) CORONARY ARTERY DISEASE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES MELLITUS 2 No 3 Probably 4 □Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 (
28a. Dite of Injury
(Month, Day Year) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To o the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

nes

Division of Vital Records, P.O. Box 68760

State

29b. Signature and title of certific

SUNIL GUPTA, M.D.

625 KENT AVENUE

30. Name and address of person who ampleted cause of death (Item 23a) (Type, Print)

29c. License number

D33280

CUMBERLAND, MD 21502

29d. Date signed (Month, Day, Year)

17,2005

Robert L. Wynn 05-03182 dl

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	State Amend Item 2	State o	f Marylai <b>6843,0</b> 5/	nd / Depa 25/05 <b>ah</b>	artment of H	lealth a	and Me	ental Hyg	iene 2 ()	05	1734	Ü
			1. Decedent's Name (First, Middle,							2. Date of Deat		Year	3. Time of Death	
	Physicia /Medic		Robert Lodge Wy	nn						May 7,	2005		7:30 P M	
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	Funeral		5. Social Security Number	5. Sex 1∰ M 2□ F	7. Age (In yrs	. <i>iast birthday)</i> 34 Yrs.	Months Days	Hours	Min.	B. Date of Birth (Month, Day, Dec. 6,	, Year)	Coul		
Ь.	Director	-	213-15-7339 Usual Residence of Decedent			74				bec. o,	1970	mai	yland	_
	yland iow		10a. State 10b. County		10c. C	ity, Town or Lo	ecation					1	Od. Inside City Limits	
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	or 28g	Funeral Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen of V	Vhat Cou	ntry?	
	th wit	aiD	637 Bethany Br	eeze			19970	)			USA			
	ems	Iner	11. Marital Status	Armed Fo	edent Ever in torces?	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba	lispanic Orig an, Mexican	igin? (Spec n, Puerto R	ify Yes or No- ican, etc.)		e - Americk, White,	can Indian, etc.	
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<u>lan</u>	Ald be Aenta rked tic av	ToB	Richard Nevin V	Jynn				Jud	dith '	"Britti	ngham"			
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	i and 2 Health a tam 27 is		Judith Brittingh	nam Bye		-	Avensong	Cross		-				
altimore,	toges 1 and 2 should be filed within 72 hours after death with the Marylan in of Health and Mental Hygiens.  If item 27 is marked other than "natural", or Items 23a or 28a-1 show if item 27 is marked other than "natural", or Items 20a or 28a-1 show or other traumatic event, it a Marical Examilier must be multified at		20a. Method of Disposition  f ☐ Burial 2 ☐ Cremation	3 □Removal from		Place of Dispo cemetery, crea	sition (Name of matory or other plac	сө)	Da	ate	20c. Location -	City or To	own, State	
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Balt	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral Service L	icens MOO8		P l	2.Name and Addre arsell Fu 6961 Kinş	ess of Facility Inerall gs Hig	Home ghway	es & Cr , Lewes	ematori , DE l	um 9958		
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that	caused the dea	ath. Do not en	ter the mode of dyir	ng, such as	cardiac or	respiratory arr	est,		Approximate Interval Between	
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	/Medical		resulting in death)	Due to	(or as a conse	quence of):		19						_
	Examiner	.	Sequentially list conditions.	b										
	p ==	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a conse	quence of):								
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87	physi physi the b	dic		d										
9 x	The law requires that the death certificate be executed tile has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant		tcome of preg						23d. Da	te of deliv	ery	
Вох	leath atter	ciar	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Preg	birth 2∏Fe nant at time of		☐Ectopic pregnanc: ☐ Other (specify) _	у			Мо	nth	Day Year	
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Д,	s that ned b	by P	Part II. Other significant condition	ns contributing to d	death but not re	esulting in the u	ınderlying cause gıv	ven in Part I	ł.	23e. Did to	bacco use cont	ribute to t	he cause of death?	
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ta		0	25. Was case referred to medical					26. Place	e of Death	(Check only or	ne)		_	
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Division	if or Attand after death Diractor: )	Certification:	3 Suicide 6 ☐ Could n 4 ☐ Homicide determi	ZOB. Flav	e of Injury - At ling, etc. (Spec	home, tarm, st cify)	reet, factory, office						IK, Of	
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	o tha ithin i o tha	Mec	29b. Signature and title of certifier	and ma	mor states.		29c. Licens	se number		2	29d. Date signe	d (Month,	Day, Year)	_
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	103	•	30. Name and address of person v	who completed cau	is of death (It	em 23a) (Type	, Print)			L	acty U, 2	2005		-
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			1 - For State Registrar	State of Ma	arylan		artmen rtificat				lental H	ygiene	13 13	05	1.7	31.6
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	D.		Usual Residence of Decedent													
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	Ba-f	ecto	Maryland Frederi	.ck		Mt. A										- 2 <u>A</u> 140
	with t	Ö	10e. Street and Number  13896 Foggy Botton	Court			10f. Zip	2177	' <b>1</b>			_	izen of W ited			
	4 within 72 hours after death with the Maryland liene. r then "neturel", or items 23s or 28e-f show the Mackeal Examinar must be notified at	Funerai Director	11. Marital Status	12. Was Decedent	Ever in U.	S. 13.				gin? (Sp	ecify Yes or N				can Indian.	
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Maryland	<u>ਲੂ ਰ ਜ਼ ਜ਼</u>	F	19a. Informant's Name/Relationship (T)	/ре, Print)		19b. Mailir	ng Address	(Street a	<del>-</del> -		al Route Numi	ber, City o	or Town,	State, Zij	Code)	
	nd 2 lith a 27 is r tra		Darlene Wright /	Daughter		4030	Roop	Rd.	, Nev	v Wir	ndsor,	MD 2	1776			
Baltimore,	es 1 and of Healt fitam 2 r othar		20a. Method of Disposition  1 XBurial 2 Cremation 3 F		20b. P	lace of Dispo	sition (Nan	ne of ther plac	e)	- [	Date	20c. Lo	ocation -	City or T	own, State	
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rds	w require been sig should b										1 🗆	Yes 2	□No	3 🗌 Prot	ably 4	Unknown
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<u>S</u>	- 9	Serti	4 Homicide	building, et	c. (Specify	1)					City or To	own, State	)			
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,	tha Hin 24 tha 54 tha 54 mplete	ledical	one)	and manner sta	ated.	tion and/or in				tn occurr	ed at the time					s)
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	~		30. Name and address of person who co	ompleted cause of the	eath (Item	23a) (Type,	Print)	ENT	TER	51	#109	m	T. A.	1014.	mp.	2177/
	Sta	te	31. Date filed (Month, Day, Year)	32. Projetr	ar's Signa	ture	Annah.	9	, _ , _					//	/	
	Registr	3	MAYIIZ	005	Aller .	J.J. P										

		1	For State Registrar	State of M	aryland / Dep	artment of F			giene Reg. No.	5 17347
			Decedent's Name (First, Middle,	, Last)				2. Date of De.	ath	3. Time of Death
	Physici: /Medic		PUI-KING W	ONG				05	07 200	
	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	or Location of De	eath	4c. County of	Death
			Howard County (	General Hosp	oital ge (In yrs. last birthday		lumbia   If Under 24 H	Irs. 8. Date of Bir	Howa	
	Funeral Director		020 26 6281	1 M 2 F 7. Ag	68 Yrs.	Months Days		June 1	Y. Year) 4. 1936	Birthplace (State or Foreign Country) China
			Usual Residence of Decedent					1		
	filed within 72 hours after death with the Maryland Hygiene. uther than "netural", or Items 23e or 28e-f show with the Medical Examiner must be nutified at	_	10a. State 10b. County		10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 X No
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	s within 72 hours after death with the Marylan tiene. r then "netural", or leters 23e or 28e-1 show the Medical Examinet must be nutified at	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
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	be filed v tal Hygie d other t event, th	e Co	17. Father's Name (First, Middle, I	·	Hoi	псшакет	18. Mother's N	Name (First, Middle,		
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Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked eny Injury or other traumatic evonce.	Η.	19a. Informant's Name/Relationsh	nip (Type, Print)	19b. Mai	ing Address (Street		Rural Route Numb	er, City or Town, St	ate, Zip Code)
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Baltimore,	of He roth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 □ Removel from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other pla		Date	20c. Location - Ci	
Ĕ	Pagenent Henrich		'4 □Donation 5 □ Other (Sp		Parklawi	Mem Parl	, ,	/9/2005		e, Maryland
ä	eparti eparti nporti ny Inj		21. Signature of Funeral Service I	Licensee			-	lines Rin		
_	g ∪ = ⊕ a		thurs	Alene				-		ing, MD 20904
			23a. fart1. Enter the disease, or hock, or heart failure. List	only one cause on each I	ine.			1 1		Approximate Interval Between Onset and Death
-10	Physician		Immediate Cluse (Final disease or condition resulting in death)	a		Yocard	191	Intarc	tion	
	/Medical Examiner			Due to (or as	a consequence of):					
		-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of).					
	uted J ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
o,	exec an an rial-tra		resulting in death) Last	Due to (or as	s a consequence of):					1
1760	certificate be executed ading physician and ise as the burial-transit	Physician/Medical		d						
89	2 4 10	Med	IF FEMALE:							
Вох	death certif e attending ed for use a	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnanc	;y		23d. Date of Month	·
0	0 0	yslc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregnant a 9☐Unknown	at time of death 5	Other (specify) _				
ď.	law requires that the de as been signed by the a 2 should be detached f		Part II. Other significant condition	ons contributing to death	but not resulting in the	underlying cause gr	ven in Part I.	23e. Did t	tobacco use contrib	ute to the cause of death?
ds	uires sign ld be	d by						_ 1 🗆	Yes 2□No 3	Probably 4-QUnknown
Records,	w requir	Completed						24a. Was	an 24b. We	ere autopsy findings available
_	The lav	ошь							ormed? dea	or to completion of cause of ath?  Yes 2 No
Vital		a)	25. Was case referred to medical				26. Place of	Death (Check only o		
<u></u>	Physici this cer al direc	To B	examiner? 1	Hospital: ⊕ Inpat	ient 2 ER/Outpati	ent 3 DOA	her: 4 Nursin	ig Home 5 ☐ Resi	dence 6 □Other	(Specify)
Division of	Attending Physician: or death. ector: After this certific: by the funeral director,	:uo	27. Manner of Death 1☆ Natural 5 ☐ Pendin	28a. Date of Inj (Month, Da	ury 28b. Time ay Year) Injury	Wo	rk?	28d. Describe	how injury occurred	
Sio	lendil eath. tor: A the fu	catle	2 Accident investig	gation			]Yes 2 ☐No	OOK Leasting (	Canada and Alumbo	as Dural Payta Mumbas
Ë		Certification;	4 Homicide determ	ined 286. Place of If	njury - At home, farm, s etc. <i>(Specify)</i>	treet, factory, office		City or To		or Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		29a. Certifier 1/J Certifyin	g Physician: To the bes	t of my knowledge de-	th occurred at the ti	ime date and o	ace, and due to the	cause(s) and man	ner as stated
S	the Hospital nin 24 hours a the Funeral I npletely filled	Medical		Examiner: On the basis in	of examination and/or	nvestigation, in my	opinion, death o	ccurred at the time.	date and place, an	d due to the cause(s)
KK	To the Hospital within 24 hours a To the Funeral completely filled	Me	29b. Signature and title of certifier	r		29c. Licen	se number		29d. Date signed (	'Month, Day, Year)
			1 dri			DI	4372	5	5/71	05
	3		30. Name and address of person	who completed cause of	death (Item 23a) (Type	a, Print)		A -		mp 21121
				CIODMAIA	201-100	i Back	Rive	2 Nec	16 Rd	Month, Day, Year) 05
	Sta		31. Date filed (Month, Day, Year)	2005 Regist	trar's Signature	well				
	Regist	rar	B O YAM	LUUJ CHE	1 20 1					

	1	For State Registrar	State	of Maryla	ind / Depa	artmen rtificate				_	giene Reg. No	7111	)5	17340
Physicia	n	Decedent's Name (First, Middle								2. Date of De Month	Da		ear	3. Time of Death
/Medića Examine		Jeanne K sa. Facility Name (If not institution		eber umber)		4b. City,	Town, or	Location	of Death	May	5,	2005 County of	Death	7:25 P
LAGITITIO		Brooke Grove	Nursing	Home		Sa	andy	Spri				Montgo	mer	У
Funeral		5. Social Security Number 131–16–3441	6. Sex 1 □ M 2 1 F		s. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da July 3,	th y, Year,	9	Coun	**
Director	-	Usual Residence of Decedent		80	) 115.					July 3,	19	24	New	York
yland		10a. State 10b. County		10c. (	City, Town or Lo	cation							10	0d. Inside City Limits
e Mar	cto	Maryland	Montgome	ry	Sil	ver S	Sprin	ng						1 ☐ Yes 24☐ No
if the core	Director	10e. Street and Number				10f. Zip	Code				10g. Ci	itizen of Wha	t Coun	try?
s 23a	Funeral	9 Finsbury Pa		cedent Ever in	118 12		20906		igin? (Cno.	oity Voc or No		USA 14. Race -	Amoric	an Indian
ter de	-nu	<ol> <li>Marital Status</li> <li>Never Married 2 Marr</li> </ol>	Armed F							cify Yes or No Rican, etc.)	,-	Black, 1	White,	etc.
al', o	2	3 Nidowed 4 □ Divorced	If Yes, G Year or	ive	60	1□Yes 2	2⊠ No	Specify:				Specify: W	hit	е
72 ho	Completed	15. Deceden (Specify only higher		0	16a. Dece	dent's Usua kind of woi DO NOT us	l Occupa	ation Juring mos	st of workin	ng	16b. K	Kind of Busin	ess/Inc	dustry
within the control of	d I	Elementary/Secondary (0-12)	College 4	(1-4or 5+)		oo not us memak		)				O II		
be filed within 72 hours eiter death with the Maryland tal Hygiene. Id other than "natural", or Items 23a or 28a-1 show event, the Madical Examirer must be netlified at	္မွ	17. Father's Name (First, Middle,			nc	шешак	er	18. Mothe	er's Name	(First, Middle		Own Ho n Sumame)	me	
Mental Red C	0	Edward J. Kee	fe					Kath	ryn E	Brady				
permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, the Madical Examiner must be publicated at once.		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rural	Route Numb	er, City	or Town, Sta	te, Zip	Code)
and and mark		John Weber/ S	on	1004	14211	Denr	ingt	on P	lace,	Rocky				
Pages 1 nent of H ant: If ites		20a. Method of Disposition 1 □ Burial 2 1 Cremation		n State	. Place of Dispo cemetery, crei	natory or o	ther place		May			ocation - Cit		
mit. Pages partment of portant: If it y Injury or or or or or or or or or or or or or	-	<ul><li>4 □ Donation 5 □ Other (S</li><li>21. Signature of Funeral Service</li></ul>		lwe	tropolita				2005					Virginia
permit. Departition in month and Injury Injury Injury Injury 2000.		Value of	1/1/1	_	50	O Uni	vers	ity	ins f Blvd,	uneral W, Si	Hor lver	me Inc r Spri	ng,	MD 20901
3 - 5 - 5	7	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the de	eath. Do not ent	er the mod	e of dying	g, such as	cardiac or	respiratory a	rrest,		Ť	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	-		Heart	Failu	re							Onset and Death  3 Weeks
/Medical·		resulting in death)	a	o (or as a cons		Tullo							$\top$	э меека
Examiner	_	Sequentially list conditions,	b	hemic C	ardiomy	opath	ıy							3 Months
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es that the death certification by the attending place detached for use as t	hysician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of preg birth 2 Fe gnant at time or	etal death 3	Ectopic pr						23d. Date o Month		ry Day Year
the de ched	iysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk		oeam 5	J Other (Sp	өспу)							
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w requires w requires been sign should be										1 🗆	Yes 2	No 3[	Prob	ably 4 □Unknown
law requ	Completed									24a. Was		24b. Wer	e autor	osy findings available inpletion of cause of
	50									perfo	rmed?	dea	th?	2□ No
OI VIIGI REC Physician: The law trhis certificate has tral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:				A Othe			(Check only o				
Phys ral dir	2	1 ☐ Yes 2 🔀 No 27. Manner of Death	1 1	Inpatient 2 e of Injury	☐ ER/Outpatier 28b. Time o		n	4 22 140		ne 5 Resi			Specify	)
Attending r death.  ctor: After by the fune	ation	1 Natural 5 Pendin 2 Accident investi	g (Mo	nth, Day Year)	Injury	м	8c. Injury Work 1 🔲 🗅	(? Yes 2 🗌			,	,		
Atter ar dea ector by the	ertification:	3 ☐ Suicide 6 ☐ Could determ	ined 208. Plat	ce of Injury - At	home, farm, str	eet, factory	, office		2	8f. Location (			r Rura	Route Number,
rs effection	Cer		- Juli	ding, oto. (opo										
To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director.	edical		g Physician: To the Examiner: On the and ma											
	Σ	29b. Signature and title of certifie	dan	* 100	D	290		number			29d. Da	ate signed (A	fonth, i	Day, Year)
7		30 Name and address	who completed ca	-		Print	D24	543			Ņ	May 6,	20	05
		30. Name and address of person James A. Rossi	·		. Leisu		rld	Bl vd	, Sil	ver Sn	rino	r.MD 2	090	5
Stat Registra		31. Date filed (Month, Day, Year)  MAY 0 9			gature do				, ~11	.cr pp			550	×

Registrar DHMH 17 Rev 1/2001 James V. White 05-3111 AKG

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- State Unpend Item 23a,27,28a-f per me fine at 6-75 Death tas Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 5, 2005 Year **Physician** 7:22 A V. WHITE JAMES /Medical 4a. Facility Name (If not institution, give street and number) 815 Thayer Avenue #612 4b. City, Town, or Location of Death Silver Spring 4c. County of Death Examiner Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day Year) | 9. Birthplace Country | 1. 14, 198 | 5. D. C. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1**X** M 2□ F 20 578-11-1193 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Silver Spring Director MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 U.S.A. 20910 815 Thayer Ave items 23a Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ž No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married 6 Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black δ 3 ☐ Widowed 4 ☐ Divorced naturel', Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7. Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) Private 12th Photographer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental h Cynthia White Maurice Thames 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) is 1 and 2 s of Health an Item 27 is Cynthia White- Mother 14905-C Cleese Ct Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once. 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Metro Fnrl Svcs 5/18/2005 Alexandria, VA 1 4 ☐ Donation 5 ☐ Other (Specify) Snowden Funeral Home, P.A. 22. Name and Address of Facility 21. Signature of Funeral Service License 246 N. Washington St Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician aAsphyxia complicating alcohol and diphenhydramine intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated accepts.) Due to (or as a consequence of) Examiner use as the burial-transit certificate be executed that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No ģ 5 Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 D¥es 2□ No 1⊠Yes 2□No 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 4 ☐ Nursing Home 5 ☐ Residence 6XXOther (Specify at Scene 28d. Describe how injury occurred subject placed plastic bag over head with tube 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: To the Hospital or Attending : 10ry 1 Natural 5 Pending investigation found a death. 1 ☐ Yes 2 No 5-5-05 2 Accident to hellum tank took medications ector 6 Could not be 3 X Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State 815 Thayer Avenue determined 4 🗌 Homicide Silver Spring, found in house Maryland 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai within 24 ho To the Functional 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME May 6, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.I 111 Penn Street Baltimore, Maryland 21201 reendery 6 d Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar	State of	f Marylan		artment rtificate			and M	lental Hy	giene Reg. No.	201	15	17251
	Physici	an	Decedent's Name (First, Middle,								2. Date of De Month	eath Day	,	Year	3. Time of Death
	/Medic	al		CZPATRICK			44 63 7			1 D 41	May	05		2005	1:00 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, 14677 Kelmscot		nber)		4b. City, T						County o		PTT.
	Funeral	•			7. Age (In yrs.	last birthday)	If Under 1	Year	Spri	24 Hrs.	8. Date of Bir (Month, Da		Mont		L y lace (State or Foreign try)
Ш	Director		577.24.4763	1 ☐ M 2 🔀 F	84	Yrs.	Months	Days	Hours	Min.	June 7	, 19:	20 1	Vashi	ington, DC
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10	0d. Inside City Limits
	Maryll f sho	or	Maryland Montgo	nma <b>r</b> v		lver S									1 ☑ Yes 2 ☐ No
	r 28a	Directo	10e. Street and Number	mery	51	TVEL D	10f. Zip (	Code				10g. Citi	zen of Wi	nat Count	try?
	hours after death with the Maryland tural', or Items 23a or 28a-f show a Exertirer must be notified at	aiD	14677 Kelmscot	Drive			20	906				U.	S.A.		
	r dea	Funeral	11. Marital Status	Armed For	dent Ever in U	.S. 13.	Was Decede	ent of Hi	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	0-		- America White, e	an Indian, etc.
36	s afte		1 Never Married 2 Marrie 3 XWidowed 4 Divorced	ed 1 ☐ Yes If Yes, Giv Year or Da	е		1□Yes 2	₩ No	Specify:				Specify:		
9	thour	Completed by	15. Decedent		105.	16a. Dece	dent's Usual	Occupa	ition			16b. Kir	nd of Bus	iness/Ind	lustry
215	hin 72 an "na Madii	plet	(Specify only highest Elementary/Secondary (0-12)	college (1	-4or 5+)	(Give	kind of work DO NOT use	done d retired	u <i>ring m</i> osi	t of worki	ng				Applied
21	ad wit	Сош	12th			] ]	Data P	roce					ic L		
nd	be file	Be	17. Father's Name (First, Middle, L	•							(First, Middle			)	
ryla	hould d Mer marke matic	P	Dennis Fitzp  19a. Informant's Name/Relationsh	atrick		19h Maili	na Address /	(Street a	Ros		A GOIII	nolly		tate 7in	Code
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at ance.		Patricia A. Kin		r						Damas	-			
	f Hea		20a. Method of Disposition		20b. F	Place of Dispo			-		ate		cation - C		
E O	Page nent o nnt: #		1 ☐ Burial 2 ☑ Cremation  1 ☐ Donation 5 ☐ Other (Sp							05/	10/05	Bren	twoo	d, M	aryland
Baltimore,	permit. Departn Imports any inju		21. Signature of Funeral Service L	icensee		H <sup>22</sup>	2. Name and INES-R	Addres	s of Facilit	INER	AL HOMI	7. TN	IC.		
	20529		Nacy A.	Versen	ب	[1.	1800 N	ew l	lamps	hire	Ave,	Silve	r Sp	ring	, MD 20904
n.			23a. Part1. Enter the disease, or shock, or heart failure. List of	omplications that cannot one one	aused the deat ach line.	th. Do not ent	ter the mode	of dying	g, such as	cardiac o	or respiratory a	irrest,			Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	reni	mou	10								2WKS
ρ	Examiner			Due to (	or as a conseq	(uence or):									
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (	or as a conseq	quence of):									
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8760,	ate be executed hysician and the burial-transit	E	resuming in death) Last	Due to (	or as a conseq	quence of):									
687	physics the l	dicai		d											
Вох (	death certificate e attending phys id for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out								2	23d. Date	of deliver	ry
	death e atte	icia	in the past 12 months?	4☐Pregn	irth 2 □Feta ant at time of d		⊒Ectopic pre ⊒ Other (s <i>pe</i>						Mont	h I	Day Year
P.0	that the d ed by the detached	hys	9 🗆 Unknown	9□ Unkno											
	ign be	by	Part II. Other significant condition	as contributing to de	eath but not res	sulting in the u	nderlying ca	use give	n in Part I.					A	e cause of death?
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Vital Records,		e Co	25. Was case referred to medical					<u> </u>	OC Plans	of Dooth	1 Yes	24 No			2 No
	Physician: this certific ral director,	OB	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 🗆 II	npatient 2	ER/Outpatier	nt 3 DO	Othe			ne 5 X Resi		5 □Other	(Specify	·)
n of	ding Ph h. After thi funeral	T :uc	27. Manner of Death	28a. Date of	of Injury th, Day Year)	28b. Time o	f 28	lc. Injury Work			28d. Describe				
Siol		catic	2 Accident investig 3 Suicide 6 Could n	ation			М	1 🗆 Y	′es 2 🗆 !						
Division	l or Atten after deat Director: I in by the	Certification:	4 Homicide determi	ned 286. Place	of Injury - At h ng, etc. <i>(Specii</i>		reet, factory,	office			28f. Location ( City or To			or Rural	Route Number,
	e Hospital 24 hours a e Funeral D letely filled		29a, Certifier 1 🕮 Certifying	g Physician: To the	best of my kno	owledge deat	h occurred a	t the tim	e date an	d place	and due to the	cause(s)	and man	ner as sta	ated
5	T 4 II' A	edical	(Check only 2 Medical E	xaminer: On the ba	asis of examina	ation and/or in	vestigation, i	in my op	inion, dea	th occurr	ed at the time.	date and	place, ar	d due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		- ~		29c.	License	number			29d. Date	e signed	(Month, E	Day, Year)
	(		K,N	$\sim$	17		$\Box$ D	23	120	<u> </u>		MA	Y (	9	2005
	1		30. Name and address of person v	1 1	m . m			1 0	In In.	v c	PRINE	RI	10	1117	V. MA
	Sta	to	31. Date filed (Month, Day, Year)	MACH	egistrar's Signa	101 0 aturo	LIVE	1-7	(171)	7 >	1-121100	IV.	ט כ	776	· 7 ) [VIO
	Registi			2005	egistrar's Sign	Apre	العام								

		,	1 - For State Registrar	State of Ma	aryland		artment tificate			ind M		giene Reg. No.	05	17352
	Physica /Media		Decedent's Name (First, Middle, Last)     Janie L. Zehfuss								2. Date of Dea Month M Gy	Day	Year 2005	3. Time of Death
	Examir	ier	4a. Facility Name (If not institution, give s  Mariner Hea)  5. Social Security Number 6. Sex	th of 1	Bel A		4b. City, 1	2/	A /	_	/ 2 Date of Bird	H	ty of Death	
	Funeral Director			M SEF	92 92	Yrs.	Months	Days	Hours	Min.	8. Date of Birth	1912	9. Birthp Coun Nort	lace (State or Foreign The Carolina
	Maryland a-f show	tor	10a. State 10b. County  Md. Harford		10c. City, T Be	own or Lo							11	0d. Inside City Limits 1 ☐ Yes 2☐ No
	th with the 23a or 28s	Funeral Director	10e. Street and Number 410 E. MacPhail Rd				10f. Zip (	Code 21014	1			10g. Citizen of		try?
9600	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, the Medical Eventries must be rediffed at once.	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	2. Was Decedent I Amed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give X Year or Dates:		j	Vas Decede i Yes, speci □ Yes 🏖		spanic Origin, Mexican Specify:	jin? (Spe , Puerto i	cify Yes or No- Rican, etc.)	14. Ra Bla Speci	ice - Americ ack, White, o ify: Whi	etc.
21215-0036	ad within 72 h /giene. ar than "natu t, the Modica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5 2yrs		(Give life. L	lent's Usual kind of work DO NOT use Nurse	k done d e retired)	tion uring most	of workir	ng	16b. Kind of B		ustry
Maryland	should be filk and Mental Hy markad oth umatic evant	To Be	17. Father's Name (First, Middle, Last)  Benjamin F. Flem  19a. Informant's Name/Relationship (Type)			19b. Mailin	a Address		Sus	ie	(First, Middle,  Ross  Route Numbe			Code)
	ges 1 and 2 in of Health are if itam 27 is or other traces		Phillip Zehfuss/so  20a. Method of Disposition  1 Burial 2 Cremation 3 Re			2813	_	ge V	iew I	Drive	e Churc		Md.21	028
Baltimore,	permit. Pag Department Important: any injury o		'4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	-	Metro MOO845	22	mator Name and	Address	s of Facility	5/9/2 Hari Dia E	y H.Wi	Catons tzke's licott	Famil	Md. y F.H.Inc. Md. 21043
	Pnysician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused e cause on each lin Due to (or as	the death. [	So not ente	or the mode	of dying	\	eardiac or	4	rest,		Approximate Interval Between Onset and Death
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8760,	death certificate be executed e attending physician and nd for use as the burial-transit	dical	that initiated events resulting in death) Last	Due to (or as	a consequen	ce of):								
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rds, P	The law requires that the site has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions con	tributing to death bu	it not resultin	g in the un	derlying ca	use give	n in Part I.		23e. Did to		tribute to the	e cause of death?
al Records,		Completed									24a. Was a autops perform	med?	prior to com death?	sy findings available apletion of cause of
ion of Vital	Attanding Physician: Th r death. actor: After this certificate by the funeral director, pag	tion: To Be	25. Was case referred to redical examiner?  1  Yes 2  Ho  27. Man of Death 1  Natural 5  Pending 2  Accident investigation	ospital: 1  Inpatie 28a. Date of Injur (Month, Day		Outpatient b. Time of Injury		c. Injury Work	Nur	sing Hom	(Check only or te 5 Theside 8d. Describe he	ence 6 Otl		
Division	P Gird	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubulg	ry - At home . (Specify)	, farm, stre	et, factory,	office		2	8f. Location (Si City or Town	treet and Numi n, State)	ber or Rural	Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medicai (	29a. Certifier (Check only one) Certifying Phys	ician: To the best of er: On the basis of and manner sta	examination	dge, death and/or inv	occurred a estigation, i	t the time	e, date and nion, death	place, a	nd due to the cod at the time, d	ause(s) and m ate and place,	anner as sta	ited. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	n/ m	Q	w	29c.	License	)   GT	P2	2	9d. Date signe May	ed (Month, D	200 E
4)08	<b>&gt;</b>		30. Name and address of person who cor	npleted cause of de	th (Item 23	a) (Type, F	Print)	P		3	Plan	STV	cet day	Devdeer
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 0 20		r's Signature	A	neut						X 12133	2.00

Zehfuss, Janie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 110 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 5:40 AM **Physician** AUSTIN WHEELER MAY 2005 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA HEALTHCARE AGNES BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year, OI • 18 • 1918 Birthplace (State or Foreign Country)

VA 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 □ M 2 🗷 F 87 217-20-2602 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State or then "neturel", or items 23e or 28a-f show The Medical Examinar must be notified at 1 XYes 2 □ No MD BALTIMORE NIA Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2928 WALBROOK AVENUE 21216 USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: à BLACK 3 MWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7. h and Mental Hygiene." 7 ie marked other then "n Elementary/Secondary (0-12) MACHINE FACTORY OPERATOR 12 TH GRADE NA 17. Father's Name (First, Middle, Last) UNK 18. Mother's Name (First, Middle, Maiden Sumame) INK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: if Item 27 ie m any injury or other treum <u>once.</u> 28 ROLLWIN CASSANDRA WRIGHT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 05-26-05 BALTIMORE MOODLAWN 21. Signa ure of Funeral Service License 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE augh 5151 BALTO. NATU PIKE, BALTO. MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician SEPSIS 48 hour disease or condition resulting in death) /Medical 8 days Due to (or as a consequence of): **Examiner** enforated Sismord Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown signed by to detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 1 Yes 2 No 2 2 No 1 Tyes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 1 Inpatient 2 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) e Hospitel or Attending Pl 24 hours after death. e Funerel Director: After the 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 212005 AS2438528-3521 duc. Baltimore MD 2/229 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Caton 900 AQUB BARALL 31. Date filed (Month MAY 2 4 2005 32. Registrar's Signature State Registrar

			1 - For State Registrer	State of Maryland /	Department of Health and  Certificate of Death	_	ne 2005 17251
Ġ	Physici /Medic		1. Decedent's Name (First, Middle, L AUD E	ARRINGZ	ON	2. Date of Death	Day Year 3. Time of Death
)	Examir		4a. Facility Name (If not institution, gr	ve street and number)  Hesp Tall Est Sex 7. Age (in yrs. last b	4b. City, Town, or Location of Deal	B Date of Right	4c. County of Death  BALT MEDILE  9. Birthplace (Seath or Foreign
	Director		216-56-7975 Usual Residence of Decedent	1□M 2ØF 68	Yrs. Months Days Hours Min.	(Month, Day, Ye	36 CVINA
	hours after death with the Maryland tural', or items 23a or 28a-f show al Examinat must be collided at	ector	10a. State 10b. County  Bal-  10e. Street and Number	imore Ra	ndalls fown	140	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	eath with	Funeral Director	9904 Cervic	Jae Lane Apt.  12. Was Decedent Ever in U.S.	101 21133		Citizen of What Country?  14. Race - American Indian.
980	ours after d ral, or item Exeminate	by	11. Marital Status 1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	<ul><li>13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer</li><li>1 ☐ Yes 2 No Specify:</li></ul>	to Rican, etc.)	Black, White, etc.  Specify: Black
215-0036	within 72 h ene. than "natu the Medical	Completed	15. Decedent's Elementary/Secondary (0-12)	Education 16 rade completed)  College (1-4or 5+)	Sa. Decedent's Usual Occupation (Give kind of work done during most of wo Me. DO NDT use retiged)	rking 16b	. Kind of Business/Industry
2	be filed tal Hygi d othar event,	Be	17. Father's Name (First, Middle, Las		\ \ /	me (First, Middle, Maid	J. Belland.Co.
, Maryland	and 2 should lealth and Men m 27 Is marks her traumatic	То	19a. Informant's Name/Relationship William Arring	ton /Husband 9	9b. Mailing Odress (Str. et and Number of A	9 90.18190	y or Town, Stap. Zip Code)
Baltimore,	Page nent o ant: # ury or		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spec	□Removal from State (Cometify)	of Disposition (Name of tery, crematory or other place) en Mount 5/2	23/05 B	altmore MD
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68760, 平	Physician /Medical Examiner per prigi- prin prigi- prigi- prigi- prigi- prigi- prigi- prigi- prigi- prigi-	icai Examiner	23a. Part1. There the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, any Learny Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	e of	in THALL	Approximate Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
	uires that the de signed by the a d be detached f	by		contributing to death but not resulting	g in the underlying cause given in Part I.		o use contribute to the cause of death?  2 □ № 3 □ Probably 4 □ Unknown
Records,	The law requir ate has been si page 2 should	Completed	FATHER THERE	to sispipations	FAILURE,	24a. Was an autopsy performed'	
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2 7 16	Hospital: 1 Inpatient 2 ER/C	Othor	ath (Check only one)	
sion of	Attending Phy or death. actor: After this by the funeral of	ation: T	27. Manner of Death  1 D Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	. Time of Injury at Work?  M 1 Yes 2 No	28d. Describe how in	
Division	2 + - C	Certification:	3 Suicide 6 Could not determined		farm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my knowled miner: On the basis of examination a and manner stated.	ge, death occurred at the time, date and place and/or investigation, in my opinion, death occu	e, and due to the cause arred at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	1. R win	29c. License number  D 1956	29d. I	Date signed (Month, Day, Year)
-	ic		2	completed cause of death (Item 23a	() (Type, Print) NoviTyula	ST HESA	CAG 20, 2005
	Sta	-	31. Date filed (Month, Day, Year)	32. Registrar's Signature	PHUDAUS	toin ne	exigland >1133
	Registr	ar	MAY 2 1 2005	Res 1 de 1	and a		

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**ORIGINAL** 

J <del>4</del> J7		State Unpend Item 23ad #1- RegistraMEND ITEM #10f		artment of Health and N	•	•	17355
Physic /Med Exam	lical	Decedent's Name (First, Middle, Last)     Naila     Aa. Facility Name (If not institution, give street a		Amahmoud  4b. City, Town, or Location of Death	May 18,	Day Year 2005 4c. County of Death	3. Time of Death 06:30 a.M
Funera Directo	1	Johns Hopkins Bayview  5. Social Security Number  216-63-4086	7. Age (In yrs. last birthday	Baltimore    If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yel	9. Birth Con 95 A	nplace (State or Foreign Intry) frica
e Maryland 3a-f show	Director	Usual Residence of Decedent  10a. State 10b. County  MD NA	10c. City, Town or L  Baltime				10d. Inside City Limits XXYes 2 □ No
A 13-0050 thin 72 hours after death with the Maryland an "natural", or Itams 23a or 28a-f show	Funeral Dire	329 Hornel Street           11. Marital Status         12. Was as a second of the status	s Decedent Ever in U.S. 13. ned Forces?	10f. Zip Code  2126 2125  Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	24	U • S • A	• ican Indian,
thin 72 hours after te.	þ	XXVever Married 2 Married 1 S Widowed 4 Divorced 15. Decedent's Education	]Yes 2 XNo es, Give ar or Dates:	1 ☐ Yes 2 ☑ No Specify:	16h	Specify: W	hite
M de will	Completed	(Specify only highest grade complete specific complete specific complete specific complete specific complete specific complete specific complete specific complete specific complete specific complete specific complete specific complete specific complete complete specific complete sp	lege (1-4or 5+) (Given life.	e kind of work done during most of work DO NOT use retired) Student	ing e (First, Middle, Maid	Schoo.	·
Laryian	To Be	Said Amahmoud  19a. Informant's Name/Relationship (Type, Pri	nt) 19b. Mail		Kanoubi	,	ip Code)
Dalliniore, IN parmit. Pages 1 and 2 Department of Health in moortant: If item 27 i any injury or other tre any.		Said Amahmoud—Faut  20a. Method of Disposition  1 \( \) Burial 2 \( \) Cremation 3 \( \) Remova  4 \( \) Donation 5 \( \) Other (Specify)	20b. Place of Disp cemetery, cre	Hornel Street, osition (Name of ematory or other place) morial Park 5/2	Date 20c.	Location - City or 1	21224 Town, State
parmit. Pages: parment of 8 Important: If ite any injury or of once.		21. Signature of Funeral Service Licensee	reh 4.	arch Hydres of Facility 300 Wabash Ave,	Baltimo		21215
Physician /Medical Examine	1	resulting in death)	se on each line.	Bicuspid Aortic Va.			Approximate Interval Between Onset and Death
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requires that the een signad by th	by	Part II. Other significant conditions contributing	ng to death but not resulting in the	underlying cause given in Part I.		1	the cause of death?
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this aldii	To B	examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 2  Accident investigation  1  Accident investigation	1 Inpatient 2 ER/Outpatie Date of Injury (Month, Day Year) 28b. Time of Injury	ont 3 DOA Other: 4 Nursing Ho	me 5 Residence 28d. Describe how in		ity)
r At	Il Certification:	4   Homicide	Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Sta	ate)	
To the Hospital of within 24 hours affice to the Funeral Discompletely filled in	Medical	(Check only 2 Medical Examiner: Or		vestigation, in my opinion, death occurr	red at the time, date a	and place, and due	to the cause(s)  Day, Year)
200	1	30. Name and address of person who complete  Parela E_Sorther, m		OCME 111 Penn Street		y 19, 200 e Marylan	
S Regis	tate trar	31. Date filed (Month, Day, Year) MAY 2 4 2005	3 Registrar's Signature			- ,	

			1 - For State Registrar	.5400	State of		nd / Depa		t of H	ealth a		lental Hy		105	1735	6
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	Physicia		GEORG	SE	C	A	DEF	2				Month MAY	Z3	Year 2005	14218	M
	/Medic Examin		4a. Facility Name (If not ins	stitution, giv	street and num	ber)		4b. City,	Town, or	Location of	of Death			inty of Death	1	
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	Funeral		5. Social Security Number	6. S		. Age (In yrs	. last birthday)		1 Year	If Under		8. Date of Bir	th	9. Birthr	lace (State or Fore	өigп
	Director		212-18-7002	1	X)M 2□F		33 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da April 10	7, 1922	L Cour	lace (State or Fore try) D.	
	ס		Usual Residence of Deced													
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	th will	by Funeral Director	7105 Dunshir	re Way	Apt	: B3		21	222				USA			
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χĮ	should be and Mental is markad c sumatic ave	<sup>o</sup> L					401 14 71		(2)				0: -	21 . 7	2.11	
Maryland			19a. Informant's Name/Re Kevin Ader	mationship (	rype, Print) SOI	า	1					<i>l Route Numb</i> e, Mary		wn, siaie, zij 21219	Code)	
	1 and Health am 27 thar tr		20a. Method of Disposition									ate		on - City or To	wn State	
وّ	Pages nent of h ant: If its arry or o		1 ☐ Burial 2 🛛 Crem	nation 3		iale	Place of Dispo									
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Baltimore,	parmit. Pages 1 and Department of Health Important: If itam 27 any injury or othar tr once.	1. 19	0/ 00-0	my (	- Cor	rnel	ky 7	7110 S	Solle	ers Po	oint	ome Of Road,	Dundal	k,P.A. k,MD.	21222	
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	/Medical		resulting in death)		-	or as a conse			,							
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	יי ק	Examiner	Sequentially list conditions and any, loading to minious cause. Enter Underlying Cause (Disease or injury		Dua to (c	a conse	quence of):	A 4		0	,					
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٥.	hat th od by detacl	Ph	Part II. Other significant of	onditions	ontributing to de	ath but not re	sufting in the u	nderlying ca	ause dive	n in Part I		23e, Did 1	obacco use c	contribute to the	ne cause of death?	>
ds,	signe signe d be		1 1	enos i	-	Litral	Regur	1.1	4 2			1 🗆	Yes 2□No	o 3 ☐ Prot	ably 4 Unkno	own
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al F												1 ☐ Yes	2 No	1 ☐ Yes	21 No	
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of	Phys this ral di	<u>۲</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death		28a. Date o	_	28b. Time o	_	/A	4 🗀 140		me 5 Resi 28d. Describe			/)	_
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Si	l or Attendi after death. Director: A I in by the fu	fica	3 ☐ Suicide 6 ☐	Could not b		of Injury - At I	nome, farm, sti	reet, factory		_	-	28f. Location (	Street and Nu	ımbər or Rura	l Route Number,	
Division	lor A after Direction by	Certification:	4 Homicide	determined	buildin	g, etc. (Spec	ify)					City or To	wn, State)			
	To tha Hospital or Attending Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 C C (Check only 2 M	ertifying Ph edical Exar	nysician: To the inner: On the ba	sis of examin	owledge, deat ation and/or in	h occurred a vestigation,	at the tim , in my op	e, date an inion, dea	d place, th occurr	and due to the ed at the time,	cause(s) and date and plac	manner as s ce, and due to	ated. the cause(s)	
	o the	Me	29b. Signature) and title of	certifier				29c	. License	number			29d. Date sig	gned (Month,	Day, Year)	
	⊢ s ⊢ ŏ		Slean	Da	lili .	MID.			230	02			MAY	23.	2005	
	10		30. Name and address of	nerson who	completed cause	of death (Ite	m 23a) (Type		_				1	/	_1555	
	Y		DEAN	DALI	Li M.	D.		JOHN	is	110	PKIN	JS B	44011	ew		
	Sta Registr		31. Date filed (Month, Day MAY 2			egistrar's Sign	nature	<i>M</i> -								

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene [] [] 5 For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death **Physician** 8:20 P M 20 2005 Jean Anita Ace May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 11700 Coastal Highway Ocean City Worcester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 5,1947 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country)
 MA **Funeral** Days Hours 1□ M 2 🕁 F 57 Yrs. 033-36-9310 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral, or Itams 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Anne Arundel Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5629 Harbor Valley Drive 21225 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced white natural', Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bank Officer Banking is markad other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Vaughan Anita Boutin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If itam 27 is any injury or other trau 5629 Harbor Valley Drive, Brooklyn, MD 21225 Mr. Ronald E. Ace / husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 X Cremation 3 □ Removal from State Chesapeake Cremation May 26,2005 Stevensville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signature of Funeral Service Licensee Mol357 1 Second Avenue, S.W., Clen Burnie, MD 21061 Parecer 23a. Pert1. E ter 15 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 6 rain lung **Physician** concu /Medical Due to (or at a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 2 Unknown Completed need 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 2Z No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 XXO ther (Specify Hote 1 1 Yes 2 No 2 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending 1- Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a ✓ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) tha within To tha 29b. Signature and title of certified 1)40959 my 53,2005 Hanovn St Bolt. Md 2/205 30. Na 'a and a drass of person we comple a cause of death (Item 23a) (Type, Print) HON Gram 300/ 2 JACK

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

MAY 2 4 2005

32 egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 19b per fh 8843 5-24-05 vt State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month 05 9:33 pm **Physician** 2005 George /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore, evindale. N/AIf Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Funeral 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Months M 2□F 89 Director 237-20-6315 30,1916N.Carolina Apr Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23 a or 28a-f show any injury or other traumatic event, If a Medical Exp. it was be notified at 2008. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Maryland Baltimore Woodlawn 1 ☐ Yes - No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3515 Melody Lane 21244 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 20 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Long Distance Truck Driver Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Wesley Allen Carrie King 19b. Mailing Address (Satand Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 89 Stone ZSt Newark, New Jersey 07104 Sylvester Allen/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5/20/05 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Community Rest Cemetery Red Springs, N.C. 22. Name and Address of Facility Chatman-HarrisFuneral Home 5240 Reisterstown Rd Baltimore, Md21215 21. Signature of Funeral Service Licensee Kh 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician CORONARY 1278/14 2415 DISEASE /Medical Due to (or as a consequence of): Examiner ILEUS I WAY Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 Yes 2 No 3 Probably 4 Thinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 Yes 1 ☐ Yes 2 ☑ No 2 No Division of Vital To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 this Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: After 1 Natural 5 Pending investigation death. 1 🗌 Yes 2 No 2 Accident Diractor: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined after 4 Homicide within 24 hours a To tha Funaral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D54739 NAM aurelles 12 14 2005 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belvedere Baltmore Maryland Avenue 21215

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) MAY 2 4 2005

. Registrar's Signature

			For State Registrar	State	e of Ma	arylan	d / Depa	artmen rtificate				iental		ene 3. No. 0 0	5	173	59	
	Physicia /Medic Examin	an	1. Decedent's Name (First, Middle, Last)  Kathryn J. Adams									2. Date of Month	1	Day 2005	Year	3. Time of 6:40	Death P M	
			4a. Facility Name (If not institution, give street and number) Sunrise of Rockville						4b. City, Town, or Location of Death					4c. County	4c. County of Death Montgomery			
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth				ast birthday) Yrs.											
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 71 is marked other than "natural; or Items 23e or 28e-f show any injury or other traumatic event, Itte Madical Exam in a must be notified at once.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Lin										ity Limits					
		rector	Maryland Montgomery Rock  10e. Street and Number					ville						g. Citizen of \	1 ☑ Yes 2 ☐ No  Citizen of What Country?			
			12809 Spring Drive					20850 U						United	Inited States			
Baltimore, Maryland 21215-0036		by Funeral Director	11. Marital Status  1 □ Nøver Married 2 □ Married  1 □ Nøver Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Dece Armed For 1 □ ∨ s ff Yes, Giv. Year or Da					Was Decedent of Hispanic Origin? (Speciff Yes, specify Cuban, Mexican, Puerto Ri				ecify Yes o Rican, etc	ify Yes or No- lican, etc.)  14. Race- Black.  Specify:			American Indian, White, etc. White		
		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  College (1-4or 5+)				(Give life.	(Give kind of work done during most of working life. DO NOT use retired)							d of Business/Industry  Own Home			
		To Be C	17. Father's Name (First, Middle, Last) Roy B. Johnson							18. Mother's Name (First, Middle, Maide Jane Lyle Porter					en Sumame)			
			19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Douglas J. Adams/Son  16707 Gooseneck Terrace, Olney, Maryland 20832															
			20a. Method of Disposition  20b. Place of Disposition (Name of Company)  20c. Place of Disposition (Name of Company)  20c. May 22,									Location - City or Town, State thesda, Maryland						
Balti	permit. I Departm Importal any inju		21. Signature of Funeral Service			M0019	Ro	Name an	Addres	s of Facility Pumph	rey ery A	Funer	al I	Home/R	ockv:	ille.	Inc.	
	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and upper to the Funeral Director, page 2 should be detached for use as the buriat-transit.	cal Examiner	M00198 300 West Montgomery Ave., Rockville, MD 20850–2805  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Coronary Artery Disease Years												ween			
Vital Records, P.O. Box 68760,			Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):										Years					
		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 5 ☐ Other (specify)									23d. Date Mont						
		5	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								•	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∰Unknown						
		Completed										24a. Was an autopsy performed?  1 Yes 2 1 No 1 Yes 2 No						
/ita		Be	25. Was case referred to medica examiner?									h (Check c				Accio	+04	
Division of V		tlon: To	1 Yes 2 X No  27. Manner of Death  1 X Natural 5 Pendi	28a. Date of Injury (Month, Day Year)  28b. Time of lnjury Work?							me 5□ Residence 6 ☑Other (Specify) Assisted 28d. Describe how injury occurred							
		Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 6 Homicide 1 See. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural R City or Town, State)										al Route Num	ber,				
		edical C	29a. Cartifier (Check only one)  1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											i)				
		M	29b. Signature and title of certifier						29c. License number 29d. [					-	Date signed (Month, Day, Year)  May 20, 2005			
	30		30. Name and address person Swaroop G. Rao						rive	, Roc	kvi1	le. N	larv	land 2	0852			
	Sta		31. Date filed (Month, Day, Year	0	32. Registr	ar's Signa	ture	_				, -	)					
Registrar MAY 2 4 2005 May & April 19																		

Registrar

State

30. Name and address of person

31. Date filed (Month, Day, Year)

MAY 2 4 2005

111 Penn Street Baltimore, Maryland 21201

who completed caued of death (Item 23a) (Type, Print)

egistrar's Signature

Miles

			1 - For State Registrar			artment rtificate			and M		Reg. No.	005	173	61
	Physic	an	1. Decedent's Name (First, Middle, La CATHERINE BR	ISCOE						2. Date of De.	Day	Year	3. Time of	
	/Medi Examir		4a. Facility Name (If not institution, gir			4b. City, 1	Fown, or	Location o		05.23		unty of Deat	5:40	AM
			1502 KING WILL	IAM DRIVE		CATO						TIMOR		
	Funeral Director			6ex 7. Age (In yrs. last bii 1 ☐ M 2 ☑ F	thday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da 08 • 17 •	v. Year)	9. Birth	hplace (State of untry)	r Foreign
	anyland show		10a. State 10b. County	10c. City, Tow	n or Lo	cation							10d. Inside Cit	ty Limits
	with the Maryland a or 28e-1 show be notified at	Director	MD BALTIN	IORE CATON	IVE	ME							1 ☐ Yes	2 <b>N</b> o
	with the		10e. Street and Number	INDA DONK		10f. Zip		2			_	of What Co	untry?	
	death w	Funeral	1502 KING WILL	12. Was Decedent Ever in U.S.	13. 1		122 ent of His	<u> </u>	in? (Spe	cifv Yes or No		USA Race - Amei	rican Indian.	
9			1 Never Married 2 Married	Amed Forces? 1 ☐ Yes 2 🔼 No If Yes, Give		f Yes, speci 1 ☐ Yes 2		Specify:	Puerto I	cify Yes or No- Rican, etc.)		Black, White		
21215-0036	72 hours after "natural", or Ite	ed by	3 Widowed 4 Divorced	Year or Dates:									ACK	
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212	be filed within 72 ho ital Hygiene. Id other than "natu event, Ire Modical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		1210LC					cosm	ETICS		
and	2 should be filed within and Mental Hygiene. Is marked other than sumatic event, the Ma	Be	17. Father's Name (First, Middle, Last	)				_		(First, Middle,	Maiden Sui	пате)		
Maryland	s 1 and 2 should if Health and Men ttem 27 is marke other treumatic	၉	19a. Informant's Name/Relationship	Type Print) 19h	Mailir	a Addross		EMM-		SMTH  I Route Numbe	- City of T	Ctata 7	To Co do l	
			ALEASE COBBS	7						. CATO				28
ore,	es 1 and of Health fitem 27 r other tr		20a. Method of Disposition	20b. Place of	Dispo	sition (Nam	e of		D	até		ion - City or 1		
Baltimore,	age ent ent y o		1 Burial 2 ☐ Cremation 3 ☐  • 4 ☐ Donation 5 ☐ Other (Speci	GARRIS	-		•	· .	6.02	४.05 (	MINO	is mi	LLS, M	D
Bal	permit. Page Department o Importent: If any injury or once.		21. Signature of Funeral Service Lice	nsee T	VA Su	Name and UGHN 51 BAL	Address	aREE	UE F	TUNERAL	. SER	VICE 21229		
				plications that caused the death. Do none cause on each line				, such as c	cardiac o	BALTO. r respiratory ar		21227	Approximate Interval Betw	)
-	Physician		Immediate Cause (Final disease or condition		ca	ncer	. 1	neto	(5+	atic			3 mon	eath
	/Medical Examiner		resulting in death)	Due to (or as a consequence										
	MET	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence	of):									
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P.O. B	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		Ectopic pre Other (spe						Month	Day Y	ear
S,	res that igned b	by P	Part II. Other significant conditions	contributing to death but not resulting in	the ur	nderlying ca	use givei	n in Part I.		23e. Did to	bacco use d	ontribute to	the cause of de	ath?
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of Vital Records,	9 4	Completed								24a. Was a autop: perfor	sy	tb. Were auto prior to co death?	opsy findings a ompletion of ca	vailable use of
tal	ician: Th certificate ector, pag	0	25. Was case referred to medical		-			26 Place	of Dooth	1 ☐ Yes (Check only or	2 No	1 🗆 Yes	2 No	
f∨i	Physician: this certific ral director,	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	tpatien	3 DOA	Othor			ne 5 Resid		Other (Speci	ify)	
0 0	ding Phy I. After thi funeral	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending		ime of njury		c. Injury Work	at ?	2	8d. Describe h				
Division	I or Attendi after death. Director: A i in by the fu	icati	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b		m str	M factory		es 2 🗆 N		9f Location (S	troot and Mi	Imbar or Ru	ral Route Numb	
Οį	al or A after I Direct d in by	Certification:	4 Homicide determined	building, etc. (Specify)	iiii, 5(/6	ser, ractory,	OHICE			City or Tow	n, State)	mber or Aur	ai Houle Numb	θΓ,
	To the Hospital or Attending Physician: whim 24 hours after deals To the Funerel Director: After this certific completely filled in by the funeral director,	edicai C	29a. Certifier (Check only one)  1 Certifying Pl 2 Medical Exer	ysician: To the best of my knowledge niner: On the basis of examination and and manner stated.	, death d/or inv	occurred at estigation, i	t the time	a, date and nion, death	place, a	nd due to the c d at the time, d	ause(s) and late and plac	manner as s	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Sonature and title of certifier	mo PHYSICIAN	1		License					ned (Month,	-	
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	1		30. Name and address of person who SYDREM BY MD	completed cause of death (Item 23a) (	Туре, і	Print) Ç	24	NOR	L17+	BROA	ALD	212	o \$	
:	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 4 20	32 Registrar's Signature	los			(	10	,,00	P-0			

			1 - For State Registrar	State of	Marylar		artmen				lental Hyg	iene 05	173	62
	Physici	an	1. Decedent's Name (First, Middle, L	ast)							2. Date of Dea Month	th Day Ye		of Death
	/Medic		Charlene Jo	Bengiov:							May 19,		0450	a <sup>M</sup>
	Examin		4a. Facility Name (If not institution, g Holy Cross Hos	ive street and numb	er)		1		Location			4c. County of D		
									Spri		0.000	Montgo	4	
	Funeral Director		275-38-9782	Sex 1 □ M 2  F 7.	Age (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day June 4	, Year) 9. 1943 La	Birthplace (State Country) ancaster	or Foreign • Ohio
	and **		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation						10d. Inside	City Limits
	Maryl f eho	ō				Wash	ingto	n. D	C				1 <del>∏</del> Ye	s 2 No
	28a	Director	10e. Street and Number				10f. Zip				1	0g. Citizen of Wha	t Country?	
	3a or	0	7405 Alaska Aver	nue, N.W.				2	0012			United	States	
	ier death with the Marylar iteme 23a or 28a-f ehow recritiset be invitited at	Funeral	11. Marital Status	12. Was Decede	ent Ever in U	J.S. 13.	Was Deced	lent of Hi	ispanic Ori	igin? (Sp	ecify Yes or No- Rican, etc.)		American Indian,	
9	or ite	Ē	1 ☐ Never Married 2 ☐ Married	Armed Force 1 Yes 2 If Yes, Give	TVNo						Hican, etc.)		Vhite, etc.	
8	ours Fai',	d by	3 XWidowed 4 ☐ Divorced	Year or Date	s:		1 Pyes 2	XIVO	Specify:			Specify:	white	
5	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f ehow he Medical Exartiner mast be indiffed at	Completed	15. Decedent's (Specify only highest of	Education rade completed)		(Give	dent's Usua kind of wor	k done d	during mos	t of work	ing	16b. Kind of Busine	ess/Industry	
12	within ne.	m	Elementary/Secondary (0-12)	College (1-4	or 5+)		DO NOT us Vil S	se retired Serv	<b>,</b>			Federal	Governme	ent
2	be filed within 7: stal Hygiene. of other than "n event, Ins Medi		17. Father's Name (First, Middle, La.	<u>4</u>		01	VII (	JET V		er's Name	(First Middle I	Maiden Sumame)		
ano	d be i	9 Be	Charles John	Bangham						guer		ines		
Maryland 21215-0036	2 should be and Mental ie marked o aumatic eve	ပ္	19a. Informant's Name/Relationship			19b. Maili	ng Address	(Street 2				, City or Town, Star	te, Zip Code)	
	od 2 lith a 27 ie r trau		William Lewell	en/Brothe	r-in-	law 4:	314	Flo	dden	Cour	t. Woodl	bridge, V	A 22192	
ē,	s 1 and 2 f Health item 27 other tr		20a. Method of Disposition		1 ,	Place of Dispo	osition (Nan	ne of			Date	20c. Location - City		
Ë	t. Pages 1 rtment of H rtant: if ite njury or ot		1 ☐ Burial 2 X Cremation 3 1 ☐ Donation 5 ☐ Other (Special Control Co	□Removal from Sta cify)	ate Ci	hesape	ake Cı	rema	fory	5/2	1/05	Beltsvi	lle, MD	
Baltimore,	permit. Page Department of Important: if any injury of once.		21. Signature of Funeral Service Lic	7	44.5.0	IR:	2. Name an	mer	al an	d Cr	emation	Services	22212	
			23a. Part1. Enter the disease, or co	mplications that cau							ver Spri		20910 Approxim	ate
			shock, or heart failure. List on Immediate Cause (Final	ly one cause on eac	h line.								Onset and	
	Pnysician /Medical		disease or condition resulting in death)	a Due to (or	Multi	le Scl	leros	is					1	
	Examiner					cysh'h'								
١,		ē	Sequentially list conditions, if any, leading to immediate		as a consec		3							
V	te be executed ysician and ne burial-transit	Examiner	Cause (Disease or injury that initiated events	C.	Cirrol	nosis d	of the	Liv	/er					
oʻ	a exerian ar		resulting in death) Last	Due to (or	as a consec	quence of):								
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68 ×	deafh certificat e attending phy od for use as th	Physician/Med	IF FEMALE:											
Вох	afh ce ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?		h 2 ☐ Feta	al death 3	Ectopic pr					23d. Date of Month	delivery Day	Year
0.	0 0 0	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnar 9□Unknow	it at time of o	death 5	Other (sp	ecity)					,	
Δ.	The law requires that the ate has been signed by the bage 2 should be detache		Part II. Other significant conditions	contributing to dea	th but not res	sulting in the u	inderlying c	ause give	en in Part I	l.	23e. Did to	bacco use contribut	e to the cause of	death?
Records,	sign d be	d by					, ,				1 🗆 Y	es 2 No 3	Probably 4	]Unknown
00	w require been si should I	Completed									24a. Was a	n 24b. Wer	autopsy finding	s available
Re	: The law cate has l	m d									autops perforr	y prior ned2 deat	to completion of h?	cause of
Vitai		e C	25. Was case referred to medical						26 Place	e of Deatl	1 ☐ Yes :	2 <b>X</b> No 1 1 1	Yes 2□No	
>	Physician: this certific ral director,	0 8	examiner? 1 ☐ Yes 2√☐ No	Hospital:	atient 2	] ER/Outpatie	nt 3 DO	Othe	00			ence 6 Other (	Specify)	
of	g Physical Berthi	ļ.:	27. Manner of Death	28a. Date of		28b. Time of		8c. Injury Work		7		ow injury occurred	,,	
jo	Attending For death.  ector: Affer by the funera	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigat	ion	Day roury	mjury	М		Yes 2	No				
Division	= = -	Certification:	3 Suicide 6 Could not 4 Homicide determine	286. Place of	Injury - At h , etc. <i>(Speci</i>	iome, farm, st	reet, factory	, office			28f. Location (Si City or Town	reet and Number o n, State)	r Rural Route Nu	mber,
	ours sours serail		29a. Certifier 1 X Certifying	Physician: To the b	est of my kn	owledge deat	h occurred	at the tin	ne, date ar	nd place	and due to the o	ause(s) and manne	r as stated	
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	(Check only 2 Medical Ex	aminer: On the bas and manne	is of examina	ation and/or in	vestigation,	in my o	pinion, dea	ath occurr	ed at the time, d	ate and place, and	due to the cause	(s)
	Vith To t	Σ	29b. Signature and tine of certifier	Mar			290		e number	_	2	9d. Date signed (M		
)			Marka	ATIV				DOC	061768	8		May 20,	2005	
	11		30. Name and address of person wh	o completed cause	of death (Ite	m 23a) (Type,	Print)							
	18		Dr. F. Sante				Road,	Sil	ver S	Sprin	ng, MD	20904		
	Sta Registi		31. Date filed (Month, Day, Year)	32. Reg	jistrar's Sign.	ature Cooks	9							
	negist	ul 1	MAY 2 4 2005	Fletone 1	15	STATE OF THE PARTY								

			1 - For State Registrer	State of h	viaryland		artment of H		ınd Mer		ene 0 (	15	17363
			Decedent's Name (First, Middle,)	Last)					2.	Date of Death			3. Time of Death
	Physici		Miriam H	Elizabeth	R1air	Benr	nett		l N	Month 2	1, 200	Year )5	5:15A M
	/Media		4a. Facility Name (If not institution,				4b. City, Town, o	or Location of			4c. County		3.13/1
	Examir	ier	25101 Silver (				Gaithe					gome	rv
_	Euroval	_			Age (In yrs. las	st birthday)	If Under 1 Year	,	A Hrs o	Date of Birth	1		lace (State or Foreign
	Funeral Director		218-18-4464	1□M 2☐¥F	82	Yrs.	Months Days	Hours	Min. Ja	(Month, Day,	1923	Mary	land
	_		Usual Residence of Decedent										
	yland		10a. State 10b. County		10c. City,	Town or Lo	cation					10	Od. Inside City Limits
	Mar	ţō	Maryland Montgo	omerv	Gai	ithers	sburg						1 ☐ Yes 2√ No
	7.28g	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of W	hat Coun	try?
	3a o		25101 Silver	Crest Dri	ve		208	382			U.S.A	Α.	
	within 72 hours after death with the Maryland ane. than "natural," or Items 23a or 28a-f show the Mudical Exc. inhelf. staffer relified at	Funeral	11. Marital Status	12. Was Deceder	nt Ever in U.S.	. 13.	Was Decedent of H f Yes, specify Cubi	Hispanic Orig	in? (Specify	Yes or No-		- America	
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80	urs a	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates	s:		1□Yes 2ŽLNo	Specify:			Specify:	Whi	te
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B	正主義を	Be	17. Father's Name (First, Middle, La	ast)				18. Mother	r's Name (F	irst, Middle, M	aiden Surname	e)	
<u>a</u>	Aental Aental rked c	To	Edward Leo B	lair				Ge	orgia	Eliza	beth I	31uch	er
Maryland	ges 1 and 2 should be t of Health and Mental If item 27 Is marked o or other traumatic eve	<b>-</b>	19a. Informant's Name/Relationship	p (Type, Print)		19b. Mailir	ng Address (Street	and Number	r or Rural R	oute Number,	City or Town, S	State, Zip	<sup>Code)</sup> 20882
	1 and 2 Health a tem 27 Is		Gerald A. Bennett	t - Son			Silver						
ē,	the standard of the standard o		20a. Method of Disposition		CON	ce of Dispo	sition (Name of natory or other place		Date		Oc. Location - (		
5	Page ent o nt: If y or		1 N Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe		IA I		Meth. Ce		v 5/28	3/05 W	infield	l. Ma	rvland
Baltimore,	permit. Pages. Department of H Important: If ite any injury or of	li	21. Sign ture of Funeral Senter Lice		)							•	
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			1 - For State Registrar	State of Maryland		artment rtificate			and Me		giene Reg. No.	05	173	64
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Steven Ray	Bramucci						2. Date of Dea Month May	Day 21	2005	3. Time of 0	
	Examir		4a. Facility Name (If not institution, give s Good Samartin Hos	pital	-		BA	Location o	ore			ty of Death		
	Funeral Director		5. Social Security Number  215-64-3113  Usual Residence of Decedent	M 2 F 7. Age (In yrs. last	birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min. A	B Date of Birt (Month, Date)	(0 <sup>Year)</sup> 953	9. Birthp Cour	place (State or htry) MD	· Foreign
	Ref at	tor	10a. State 10b. County  Maryland Anne Art	10c. City, To	own or Lo		Glei	n Bur	nie			1	0d. Inside City	
	th with the 23a or 28	Funeral Directo	10e. Street and Number 204 Somerset Bay Di	rive, Apt. 101	_	10f. Zip (		1061			10g. Citizen of	What Cour USA	ntry?	
036	urs after dea al', or Items Everalment	þ	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	ı	Was Decede if Yes, specif 1 ☐ Yes 2		spanic Orig n, Mexican, Specify:	gin? (Speci i, Puerto Ri	fy Yes or No- can, etc.)	14. Ra Bla Speci	ice - Americ ack, White, ify: Wh		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or items 23e or 28e-f show any injury or other traumatic event, the Medical Everth at must be indiffied at ance.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give life.	dent's Usual kind of work DO NDT use	done d retired)	uring most			16b. Kind of E		•	
/land	uld be filed Mental Hyg irked other itic event,	To Be C	17. Father's Name (First, Middle, Last)  Robert G. Brai	mucci					r's Name (		Maiden Suma Barint	me)		
Baltimore, Maryland	and 2 sho ealth and h n 27 is ma		19a. Informant's Name/Relationship (Typ. Joan S. Bramucci	(spouse)	204	Somers	set	Bay D	Orive,	Apt1	r, City or Town 01, Gle	n Bur	nie, ME	
timore	Pages 1 Iment of H tant: If iter jury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Re  3 ☐ Other (Specify)	emoval from State Metro	tery, crer O Cre	sition (Name natory or oth emator	y Ir	nc.	May S	24	20c. Location Baltimo			d
Ba	permit Depar Impor any in		21. Signature of Juneral Service License	/		3111	Mour	ntain	Road	. Pasad	ings Fu dena, M		22	
	Physician and Macing Examiner fransit	ical Examiner	23a. Part1. Enter the disease, or combile shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence  Due to (or as a consequence  Due to (or as a consequence  Due to (or as a consequence	of):	Arte	7	L	Sein	se from	esi,		Approximate Interval Betwo Onset and De	veen
O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregnancy 1 \( \subseteq \text{Live birth} \) 2 \( \subseteq \text{Fetal dea} \) 4 \( \subseteq \text{Pregnant at time of death} \) 9 \( \subseteq \text{Unknown} \)		Ectopic pred Other (spec				20 200		ate of delive	*	ear
rds, P.	quires that n signed b uld be deta	by	Part II. Other significant conditions conf	ributing to death but not resulting	g in the ur	nderlying cau	use give	n in Part I.		23e. Did to	bacco use con es 2 No		e cause of de ably 4 □Un	
		Completed								24a. Was a autops perfor 1 Yes	sy med?	prior to con death?	psy findings av npletion of cau	vailable use of
of Vital	Attending Physician: The Is redath. ector: After this certificate ha ector: After this certificate haby the funeral director, page 2	n: To Be	27. Manner of Death		. Time of	t 3 DOA	c. Injury	r: 4 □ Nurs	rsing Home		ne) ence 6 ⊟Ott ow injury occur		•)	
Division of	I or Attending I after death. Director: After I in by the funer	Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	Injury farm, str	M eet, factory,		r es 2 □ N	-	f. Location (S City or Tow	treet and Numi n, State)	ber or Rura	l Route Numbi	er,
_	Hospital 4 hours Funeral lely filled	edical Ce	29a. Certifier (Check only one) Certifying Physical Exemination (Check only one)	ician: To the best of my knowled er: On the basis of examination and manner stated.	lge, death and/or inv	occurred at	the time	e, date and inion, death	d place, and h occurred	d due to the c at the time, d	ause(s) and mate and place,	anner as stand due to	ated. the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	> ped		29c. I	License 36	-	84		9d. Date signe	1		
_	h		30. Name and address of person who con	npleted cause of death (Item 23a	(Type,	Print) AKU	100	0	Roa	d. G	S/23,	ZURNI	EN	0
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 4 200	32. Registrar's Signature	So	AKU								

			1 - For State Registrar	State o	of Marylan		artment of rtificate of		and M		giene ()	05	17365
	Physicia		Decedent's Name (First, Middle, JOHN F	Last) PRENTISS	BROWNE	-				2. Date of De May		005°	3. Time of Death 10:40A M
	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town,	or Location o				ty of Death	1011011
	-Admin		Union Me	emorial H	lospital		Balti	more				N/A	
	Funeral			S. Sex XX M 2□F	7. Age (In yrs. I	•	If Under 1 Year Months Days		Min.	8. Date of Bir (Month, Da	v. Year)	9. Birthp	place (State or Foreign
	Director		215-14-7745 Usual Residence of Decedent	XX	84	Yrs.				June 1	,1920	Mar	y1and
	yland sow		10a. State 10b. County		10c. City	, Town or Lo	cation					1	Od. Inside City Limits
	a-fsh	ctor	Maryland N/A		Ba	ltimor	е						1√Yes 2□No
	ith the	Dire	10e. Street and Number				10f. Zip Code				10g. Citizen of		ntry?
	s 23s	rail	110 Overhill Roa				2121		1.0.10			USA	
	ter de Item	Funeral Directo	11. Marital Status  1 Never Married 2 Marrie	12. Was Dec Armed Fo	edent Ever in U. orces? 2 ☐ No WW I	S. 13.	Was Decedent of f Yes, specify Cul	Hispanic Orig ban, Mexican	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)	)- 14. Ha Bla	ce - Americ ack, White,	
036	urs a	by	3 Widowed 4 Divorced	If Yes, Gi Year or D	ve	-	1 ☐ Yes 2 <b>X</b> XNo	Specify:			Speci	ify:	White
2-0	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther than "natural" or items 23s or 28s-f show avent, the Medical Examinar must be notified at	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece	dent's Usual Occu	ipation during most	of working	na	16b. Kind of E	Business/In	dustry
2	within	mp	Elementary/Secondary (0-12)	College (	1-4or 5+)		kind of work done DO NOT use retire			•	Priva	to Ei	<b>v</b> m
מ	filed v Hygie sther t	ပိ	17. Father's Name (First, Middle, L.	ast)		A	rchitect		r's Name	(First, Middle	. Maiden Suma		T111
Maryland 21215-0036	should be filed within and Mental Hygiene. s marked other than umatic event, the M	To Be	Walter Courtenay	/ Browne				Ca	ther	ine We	aver Go	rtze	
Mai	id 2 sh Ith and Ith and 27 Is m traum	i i	Janet Biedler		Wife		ng Address <i>(Str</i> ee V <b>erhill</b>						,
altimore,	ages 1 and 2 should b nt of Health and Ment: I: If Item 27 is marked r or other traumatic e		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of matory or other pla			ate	20c. Location		
Ĕ	Pages nent of ant: If It ary or o		1 Burial 2 Cremation 3	3 ∐Removal from ecify)	State	nMount	Cemetery	5	5/24/	05	Baltim	ore,	Maryland
äalt	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service U	ol niee	16	/ 22	. Name and Addr	ess of Facility	Mita	chell-Wie	edefeld F	uneral	Home Inc
<u> </u>	70E 9 9		- Ximus X	4840m	(Cuai	24					ltimore, 1	Marylar	
			23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final	nly one cause on	eaused the deatr	4				_	4		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. Due to	cute (or as a consequ	lence of):	card	al.	- to	ter c 40	~	-	30 mil
n	Examiner		Control of the contro		sonat	3	rter	7 [	Sise	açe			
7	D #	ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to	(brias a eonsequ			1					
V	and and I-trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a consequ	ience of):			_				
8760,	certificate be executed Iding physician and Ise as the burial-transit			20010	(Or as a consequ	anico or,							
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ŏ	eath certific attending p for use as	M/us	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		Ectopic pregnanc	ev				ate of delive	*
O. B	The law requires that the death te has been signed by the atten age 2 should be detached for u	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time of de		Other (specify)	·,			М	onth	Day Year
<u>.</u>	res that the de signed by the s be detached t		Part II. Dther significant condition	s contributing to d	eath but not resu	ulting in the u	nderlying cause g	ven in Part I.		23e. Did t	obacco use con	wibute to th	ne cause of death?
Records,	uires signe	d by	Hypertens	~0~		•	,			1 🗆 🕆			ably 4 □Unknown
00	w require been sign should b	lete	Ablannel	fortic A	nenth	5-				24a. Was	an 24b.	Were auto	psy findings available
Re	: The law cate has l page 2 s	Completed			- 1					autor perfo	osy ormed?	death?	npletion of cause of 2 No
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<u>o</u>	Physician: this certifica al director, I	2	1 ☐ Yes 22 No			R/Outpatier	t 3 DOA	her: 4 🗆 Nur			dence 6 □Otl		/)
חכ	ding P h. After I funera	ion	27. Mann- of Death  1  atural 5 Pending 2 Accident investiga		of Injury th, Day Year)	28b. Time of Injury	Wo	ıryat ork? ]Yes 2 □ N		8d. Describe I	how injury occur	rred	
Division	I or Attendi after death. I Director: A d in by the fu	fica	3 Suicide 6 Could no	ot be 28e. Place	of Injury - At ho	me, farm, str	eet, factory, office			8f. Location (	Street and Num	ber or Rura	I Route Number,
á	s after al Dire	Certification:	4 Homicide	build	ing, etc. (Specify	")			- 10	City or Tov	wn, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	edicai (	29a. Certifier 1 Certifying (Check only one)	Physician: To the band man	e best of my know easis of examinat oner stated.	wledge, death ion and/or in	occurred at the t vestigation, in my	ime, date and opinion, deat	d place, a h occurre	nd due to the d at the time,	cause(s) and m date and place,	anner as st and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	m	^	. ^	29c. Licen	se number			29d. Date signe	ed (Month, i	Day, Year)
			Pull		~ /	رلا	1),	12/0	77		100	7 2 3	2005
	12		30. Name and address of person w	Mc Co.		23a) (Type,		har la	es	Ba1	Lmar	1	
	Sta Registr		31. Date filed (Month, Day, Year)	32. F	Strar's Signal	ture	hands						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 12:37P M Doris G. Bohlman 2005 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fairhaven Retirement Home Sykesville Carroll If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Nov. 27, 1921 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 🖺 F 214-14-3145 Director 83 Maryland Usuel Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Exercites must be notified at 1 ☐ Yes 2 No Directo Delaware Sussex Ocean View 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 David Road P.O. Box 404 19970 Funerai U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Fitzgibbons Gertrude C. Smith ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If Itam 27 is Russell Bohlman (Son) 2056 Bandy Avenue Eldersburg, Maryland 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐Donation 5 ☐ Other (Specify) Balto/Wash Crematory 5-21-2005 Laurel, Maryland 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc.
1630 Edmondson Avenue Catonsville, MD 21228 21. Signature of Fundal Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ANo Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed: 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 - Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18 D34849 May 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road E Idershurg William Tan MD 1645 31. Date filed (Month, Day, Year) 32. pegistrar's Signature State MAY 2 4 2005 Registrar

			1 - For State Registrar	State of Maryland / [		rtment of H			iene	17367
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Juliah	Bennett				2. Date of Death		
	Examir		4a. Facility Name (If not institution, give s 2921 Baker 5. Social Security Number 6. Sex	St. 7. Age (In yrs. last bir	rthday)	4b. City, Town, or Boy Hunder 1 Year	n O r L If Under 24 Hr		4c. County of De	eath Sirthplace (State or Foreign
	Director		218-36-7505 1 Usual Residence of Decedent 10a. State 10b. County /	10c. City, Tow	Yrs.	Months Days	Hours Mir	Month, Pay,		10d. Inside City Limits
	n the Maryl r 28e-f sho	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	1 →Yes 2 □ No
	r death wit ems 23a o	Funeral D	2921 Baker	12. Was Decedent Ever in U.S. Armed Forces?	13. W	2/2 / as Decedent of His Yes, specify Cuba		Specify Yes or No- rto Rican, etc.)	14. Race - Ar Black, Wi	nerican Indian,
-0036	hours afte	þ	1 Never Married 2 Married 3 M Widowed 4 Divorced  15. Decedent's Educ	1 ☐ Yes 2 1 No If Yes, Give Year or Dates:	1	Yes 2 No	Specify:		Specify:	lack
21215-0036	be filed within 72 hours after death with the Maryland hal Hygiene. od other then "naturel" or Items 23e or 28e-f show event, the Medical Exacting to notified at	Completed	(Specify only highest grade		(Give k.	ind of work done do NOT use retired)	uring most of we	orking	6b. Kind of Busines Medic	is/industry
Maryland	ed ala	To Be (	17. Father's Name (First, Middle, Last)  19a. Informant's Name/Relationship (Type)	ardner	A 4 - 10		fanie		ompson	
Baltimore, Ma	1 and Health em 27 ther tr		Coa. Method of Disposition  1 □ Burial 2 StCremation 3 □ R.  4 □ Donation 5 □ Other (Specify)	t daughter 2 20b. Place of	92/ f Disposi	Address (Street a  Bake I  ition (Name of atory or other place  the Cremoter	st. 1	Balty . L. Date 2	City of Town, State  2121  Oc. Location - City of	4
Balti	permit. Pages Department of importent: If it any injury or o		21. Signature of Funeral Service License	Varfan	Ca	Name and Address	Ma h	ass Fune. Bald.	rul 8-12	ica P.A.
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	Due to (or as a comequence	lu	r the mode of dying	, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events casulting in death) Last	Due to (or as a consequence of						
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Records, P.	w requires that been signed t should be det	b	Part II. Other significant conditions conf	tributing to death but not resulting in	the und	lerlying cause give	n in Part I.	23e. Did toba		to the cause of death?  Probably 4 □Unknown
	ystcien: The taw ri is certificate has be director, page 2 sh	Completed						24a. Was an autopsy perform	prior to	
Division of Vital	ding Ph	atlon; To Be	25. Was case referred to medical examiner?  1  Yes 2  Ho  27. Manner of Death  1  Accident  investigation		tpatient Time of njury	3 DOA Other	. 4 ☐ Nursing H	ath (Check only one) Home 5 X esiden 28d. Describe how	ce 6 □Other (Sp	ecify)
Divis	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)				City or Town,	State)	Rural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical	one)	ician: To the best of my knowledge er: On the basis of examination and and manner stated.	, death o	stigation, in my opi	nion, death occu	irred at the time, dat	o and place, and du	e to the cause(s)
			29b. Signature and title of certifier	WN		29c. License			Date signed (Mon $05/23$ )	
	0		30. Name and address of parson who con  31. Date filed (Month, Day, Year)	814 SAND	Type, Pr	PER C	IRCLE	STE 2	u, BACIC	05 MD 21236
	Sta Registra		MAY 2 4 2005	2. Registrar's Signature	back					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 tas Registrar Amend Item 19a per fh G843 5-24-05 tas Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death CORNISH Day Month Year Physician EARL 1636 MAY 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner RANDALLSTOWN DALTIMORE HOSPITAL NORTHWEST 7. Age (In yrs. last birthday)

7. Age (In yrs. last birthday)

7. Age (In yrs. last birthday)

7. Age (In yrs. last birthday)

Nonths Days Hours Min. (Month, Day, Year)

05.28.1930 5. Social Security Number 6 Sev Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F Director 215.26.4619 Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits Show or then "natural", or Itema 23a or 28a-f show the Medical Examiner must be notified at NIA 1 Nes 2 No MD BALTIMORE Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 3130 BOARMAN AVENUE USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Myes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 K Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) ENGINEER 12 TH GRADE RAILROAD markad other other treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be f Health and Mental item 27 is marked o WILLIAM CORNISH VERA CORNISH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARION Marian Cornish (Wife) 3730 BOARMAN AVE., BALTO. MD 21215 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State ō = 6 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. GARRISON FOREST 4 Donation 5 Other (Specify) 05.31.05 OWINGS MILLS MD 21. Signalure of Funeral Service Licensee VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO NATI PIKE BALTO MO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPSIS Immediate Cause (Final disease or condition resulting in death) COLI Physician /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, by Physician/Medical attending ph for use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached f ☐ Yes 2☐ No Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? INFECTION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed' 1 Yes 24 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) nours after death.

naral Director: After this ce
filled in by the funeral direc 은 1 Yes 2 No 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Division 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 MANIMA NHC, BALTO MO 31. Date filed (Month, Day, Year) ₽egistrar's Signature 32. State MAY 2 4 2005 Registrar

			For	10030					lealth and N	-		gible.	
		_	State Registrar				Cert	ificate of	Death	R	og. No.	05	17369
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	/Medic	al	Menee						ack	May	15	2005	
	Examin	er	4a. Facility Name (If not in	11	opkins 1	11050	101	B. City, Town, o	r Location of Death	1.1.	4c. Co	unty of Death	1
	Funeral		5. Social Security Number	6. Se		e (In yrs. last		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day	)	9. Birth	place (State or Foreign
	Director		426-37-802	3 1	□ M 2 🔀 F	41	Yrs.	Months Days	Hours Min.	Feb 29,	1964		intry)
	pug M		Usual Residence of Deced	lent County		10c. City. T	own or Loca	ntion					10d. Inside City Limits
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	ith the Marylar or 28e-f show	rect	10e. Street and Number	Ince o	201800		117 110	10f. Zip Code			0g. Citizer	of What Cou	untry?
	within 72 hours after deeth with the Maryland ene. then "naturel", or Items 23a or 28e-f show the Macical Examinar must be mailfred at	Funeral Director	3112 Gumw	ood Dr	ive			2078	5			U.S.A.	
	after dee or Items	uner	11. Marital Status		12. Was Decedent Armed Forces?		13. Wa	as Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Amer Black, White	
36	s afte	by Fu	1 ☐ Never Married 2: 3 ☐ Widowed 4 [XD		1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:	No	1 0	Yes 2⊠ No	Specify:		Sp	ecify: B	lack
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pu	be fill stal Hy od oth	Be	17. Father's Name (First, I						18. Mother's Nam			mame)	
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Na Na	od 2 s Ith an 27 is r treur		Gabrielle				-	Gumwood		attsvil			p Code)
5	es 1 and 2 of Health a f item 27 is r other tree		20a. Method of Disposition	)		20b. Plac		tion (Name of tory or other place		Date		ion - City or T	own, State
2			1 ☐ Burial 2 🛣 Cren 1 ☐ Donation 5 ☐ C					1n Crem		19/2005	Bre	ntwood	, MD
Baltimore,	permit. Page Department of Importent: If any injury or ance.	Ì	21. Signature of Funeral S	Service Licen	isee /				ss of Facility For				
	205 20		Muane	U :	Casful	in			ensburg F			d MD 2	
				e. List only	one cause on each ti	ne.					est,		Approximate Interval Between Onset and Death
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687	ys ys				d								
Вох (	Physicien: The law requires that the death certificat this certificate has been signed by the attending phy rial director, page 2 should be detached for use as the	by Physician/Med	tF FEMALE: 23b. Was decedent pregn	ant	23c. If yes, outcome						23d	Date of deliv	very
	es that the death cer igned by the attendin be detached for use	Icla	in the past 12 month 1□ Yes 2□ No		1 ☐ Live birth 4 ☐ Pregnant at			ctopic pregnancy Other (specify) _	<u>'</u>			Month	Day Year
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	res tha igned be de		Part II. Other significant of	ellitu	-	ut not resultir	ng in the und	erlying cause giv	en in Part I.	23e. Did to	N2		the cause of death?  bably 4 Dunknown
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Rec	The law cate has I page 2 s	Completed		<del></del>						24a. Was a autops	sy	prior to co death?	opsy findings available ompletion of cause of
ta	Icien: Th certificate ector, pag	e Co	25. Was case referred to	medical					26. Place of Deat		2 No	1 🗆 Yes	2 No
Division of Vital Records,	ystcien: is certific director.	To B	examiner?		Hospital:	ent 2 ER	/Outpatient	3□ DOA Oth		ome 5 Resid		Other (Speci	ify)
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sio	Attending r death. ector: After by the fune	catle	2 Accident	investigation	1				Yes 2 □No				
ΟĬ	or Atten after deat Director:	Certification:	4 Homicide	determined	286. Place of Inj	ury - At home c. (Specify)	), farm, stree	t, factory, office		City or Town		umber or Rur	al Route Number,
ш	spital ours a		29a. Certifier 1X C	ertifying Ph	ysician: To the best	of my knowle	dge, death o	occurred at the tir	ne, date and place.	and due to the c	ause(s) and	d manner as s	stated.
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only 2 M one)	edical Exam	niner: On the basis o and manner st	f examination	and/or inve	stigation, in my o	pinion, death occur	red at the time, d	ate and pla	ice, and due t	to the cause(s)
	To the Hospitel of within 24 hours a To the Funerel Completely filled	M	29b. Signature and title of	certifier				29c. Licens				gned (Month,	
	6	1	Viole	nia (	- Isino	MO		KE	S-00C	$\rangle$   $I$	May 1	5, 20	005
	10		30. Name and address of	1	completed cause of o	leath (Item 23	Ba) (Type, Pr	int)	wello 60	20 12-11	Wale.	St Br	005 altimore, MD 21287
			31. Date filed (Month, Day	Siao,	32. Registr	ar's Signature	INS ITUS	prox, 10	we 119 00	~ North	VVUITE	(1)	21287
	Sta	te	MAY 2		Recei	H	Brech						

State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Charles Cieri 18 8:00 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1569 Rhinehardt Lane Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) 03-05-1916 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □X X 2 □ F 89 Yrs. 218-14-3916 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deptriment of Health and Mental Hygiene.
Important: if item 27 is marked other than "neture!" --- any iury or other traumatic average. 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 1 ☐ Yes 2ĀNo Glen Burnie MD Anne Arundel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 USA 1569 Rhinehardt Lane Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? ¥22 Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White If Yes, Give Year or Dates 1945-1946 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anne Mazza Louis Cieri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1569 Rhinehardt Lane Glen Burnie, MD 21060 Mrs. Catherine Cieri/ Wife 20a. Method of Disposition

1 Burial 2 Compation 3 Belloval from State

4 Donation 5 Other Specify 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Glen Haven Mem. Park | 05-22-2005 Glen Burnie, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Singleton Funeral Home 1 Second Ave, S.W. Glen Burnie, MD Approximate Interval Between Onset and Death 23a. Par . Ent - the ois shirck, or he in lail. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final -UNG CANCER **Physician** disease or condition resulting in death) month /Medical Examiner Sequentially list conditions, if a y, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) detached is been signed by the 2 should be detache 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobageo use contribute to the cause of death? Be Completed by 1 es 2 No 3 Probably 4 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an filled in by the funeral director, page 2 autopsy performed? Yes 2 No 2 1 No 1 Yes 1 Tes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier DOO 23811 man d address of person who completed cause of death (Item 23a) (Type, Print)

90 Form an MO 1406B S. Crain 364 Glan Burnie MD 21061 32 Registrar's Signature State Registrar

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 7 per, fb. 9843, 5-24-05, vt.

		-	Amend item / State		epartment of H			17371
	Dhoraini		1. Decedent's Name (First, Middle, Last)	~11	John Carlo	2. Date	Day Year	3. Time of Death
	Physicia /Medic	al -	4a Facility Name (If not institution give street and i	oumber) . / /)	4b. City, Town, or	r Logation of Death	4c. County of De	
Ĺ	Examin	er	Rock Chen Nuss	ng x rena	6. 10N RO	alerten 201, B	What b	County
	Funeral Director		5. Social Security Number 9 6. Sex 1 M 2 F	7. Asylin yrs. last birth	Months Davs	Hours Min. 8. Date (Mont	of Birth 9. B	irthplace (State or Foreign Country) Cy Land
	D		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town	or Location		1	10d. Inside City Limits
	a-f sho	ctor	Maryland N/A	Balt	imore			X Yes 2 □ No
	with the a or 28 the no	Director	10e. Street and Number 3612 Liberty Height	s Ave	10f. Zip Code	215	10g. Citizen of What (	Country?
	death	Funeral	11 Marital Status 12. Was D	ecedent Ever in U.S. Forces?		lispanic Origin? (Specify Yes an, Mexican, Puerto Rican, etc		nerican Indian, nite, etc.
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23e or 28e-f show event, the Madical Eramin at most be notified at		1 Never Married 2 Married 1 Yes.	s 21√2 No	1 ☐ Yes 2 € No	Specify:	Specify: B]	lack
21215-0036	72 hou	Completed by	15. Decedent's Education (Specify only highest grade complete	16a. [	Decedent's Usual Occup 'Give kind of work done life. DO NOT use retired	ation during most of working	16b. Kind of Busines	s/Industry
2121	within reference to the Me	dmo	Elementary/Secondary (0-12) College 3 Yea:	e (1-4or 5+)	ccountant		Self Empl	oyed
	be filed ntal Hygid od other event, L	Be	17. Father's Name (First, Middle, Last) Gordon Boyd			18. Mother's Name (First, M		
Maryland	ges 1 and 2 should be filed withir tof Health and Mental Hygiene. If item 27 Is marked other than or other traumatic event, the Me	ှင	19a. Informant's Name/Relationship (Type, Print)	19b. I	Mailing Address (Street	Sevilla Tri		Zip Code) 21215
	1 and 2 Health a Iem 27 Is		George Carroll, Jr.,		22 W.Cold; Disposition (Name of	spring_Lane	Baltimore,	Maryland or Town, State
more	Pages 1 nent of H int: If ite iry or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro	cemeterv	r, crematory or other plac nount Ceme	etery 5/24/0	05 Baltimor	e.Marvland
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr once.		21. Signature of Funeral Service Licersee		22. Name and Addre	ss of Facility Chatma sterstown Ro	an-Harris F	uneral Home
	905 a 0		23a. Party Enter the disease, or complications the	at caused the death. Do no				Approximate Interval Between
	Physician		shock, or heart failure. List only one cause of immediate Cause (Final disease or condition	Reroscler	tic Cara	liovasculer.	Dijeose	Onset and Death
	/Medical Examiner		resulting in death)	to (or as a consequence of	de mia			
Н	po iis	luer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	to (or as a consequence of	f):			
ά,	ate be executed obly sician and the burial-transit	Examiner	that initiated events c resulting in death) Last Due	to (or as a consequence of	f):			
8760,	icate be ex physician s the buria	dlcal	<b>d</b>					
Box 6	n certifii anding p use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes,	outcome of pregnancy	3 ☐Ectopic pregnanc	v	23d. Date of	,
	ne deat the atte	ysicla	in the past 12 months?	egnant at time of death	5 Other (specify)	,	Month	Day Year
s, P.O.	requires that the death certificate be executed eeen signed by the attending physician and hould be detached for use as the burial-transit	by Physician/Me	Part II. Other significant conditions contributing t	o death but not resulting in	the underlying cause gr	ven in Part I. 23e.	. Did tobacco use contribute	
ord		eted				242	<u>-</u>	Probably 4 Unknown autopsy findings available
Division of Vital Records,	The law ate has b page 2 s	Completed				10	autopsy prior 1 performed? death	o completion of cause of
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	-5	Ot	26. Place of Death (Check		
of	Phys	n: To	27. Manner of Death 28a. D	☐ Inpatient 2 ☐ ER/Out ate of Injury 28b. To fonth, Day Year) In			Residence 6 Other (Siscribe how injury occurred	oecny)
isior	Attending r death. ector: After by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be	ace of Injury - At home, far		Yes 2 □ No 28f. Loca	ation (Street and Number or	Rural Route Number,
Di∨	tal or A s after al Direc ed in by	Certif	4 Homicide determined by	uilding, etc. (Specify)		City	or Town, State)	
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier Certifying Physician: To (Check only one)	the best of my knowledge, se basis of examination and nanner stated.	, death occurred at the tid/or investigation, in my	me, date and place, and due opinion, death occurred at the	to the cause(s) and manner time, date and place, and c	as stated. lue to the cause(s)
	To the within To the comple	Me	296. Signature and title of certifier	ΛΑ	29c. Licen	se number	29d. Date signed (Mo	onth, Day, Year)
	2/10		30. Name and address of person who completed	23a) (cause of death (item 23a)	Type, Print)	1705	1 3/20/5	2)
-	2		LIARAT AC	1 821	Note &	uten It 1	Sallen 1	102/201
	St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 2 4 2005	Registrar's Signature	pode			

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Under Previous of December   10c. Diety Town of Location   10c. Di												(Month, D	au Vaa		Court	try) _	_
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Physician / Medical Examiner    Medical Examiner	Balt	permit. Depart Import any inj		No No	960 - L.												
Physician (Medical Examiner Cause (Please or Children Cause) (Please or Chi				23a. Party. Enter the disease, or compared to the specific state.	olications that caused	the deat	h. Do not ent	er the mo	ode of dying	, such as c	cardiac o	respiratory	arrest,			Interval Bet	ween
Due to (or as a consequence of):    Particular   Particul		Physician		Immediate Cause (Final			al B	leal								Onset and	Death <b>S</b>
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Part   Part		s tha	y P	Part II. Dther significant conditions of	ontributing to death b	ul not res	ulting in the u	nderlying	cause give	n in Part I.		23e. Did	tobacco	use contribut	e io th	e cause of c	leath?
Part   Part	rg	quire en sig	ed k									1 🗆	Yes 2	2□No 3□	] Prob	ably 4	Jnknown
Part   Part	000	aw re	plet											24b. Were	auto	osy findings	available
26. Place of Death (Check only one)  27. Was case referred to medical examiner?  28. Place of Death (Check only one)  28. Place of Death (Nonth, Death one)  28. Place of Death (Nonth, Death one)  28. Place of Death (Nonth, Death one)	Ä	0 2 0	E O				-					perf	ormed?	deat	h?		4400 01
1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)  27. Mannar of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 4 Homicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be deturmined  28a. Date of Injury - At home, Iarm, street, factory, office 28b. Place of Injury - At home, Iarm, street, factory, office 28b. Place of Injury - At home, Iarm, street, factory, office 28c. Injury at Work? M 1 Yes 2 No  28d. Describe how injury occurred 28	ita	stan: artifica ctor.	a	25. Was case referred to medical						26. Place	of Death	(Check only	оле)				
State   Stat	>	S S	0		1 Inpatie		ER/Outpatier	t 3□ E	JUA	4 🗆 Nur	sing Hon	ne 5 🗆 Res	idence	6 □Other (S	Specify	1)	
Ellist State 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ellist Share D.O. To I East Maishair Mark Pallimore, Mary land 21218  State 31. Date filed (Month, Day Years) 4 2005 32. Printer's Signature		ing P	on:		28a. Date of Inju (Month, Da	ry y Year)						8d. Describe	how inj	ury occurred			
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Elliot Share D.O. To I East Maillarhury Ballimore, Maryland 21218  State  31. Date filed (Month, Day Year), 4 2005 32. Perster's Signature		, 0	/	> EDit la.	AT				HOOL I	190			m	1 11	) 00	ς	
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				31. Date filed (Month, Day Year) 4	2005 32.	r's Signa	atura Ja			-							

			1 - For State Registrar	State of M	Marylar		artment tificate			and M	lental Hy	giene Reg. No.	00	5	17	373
	Physici	an	Decedent's Name (First, Middle, Las	•	- II - 1	0 11					2. Date of De Month	Day	Y	'ear		of Death
	/Media	cal	An English Many (16 and in air air air	Theres		en Coll		-		(5)	May	18		05	7:15	P. M
	Examir	er	4a. Fecility Name (If not institution, give Hospice of the				4D. City,		Location o				ounty of nne		ndo1	
	Funeral		5. Social Security Number 6. Se	x 7.		last birthday)	If Under	1 Year	If Under 2	24 Hrs.	8. Date of Bir					e or Foreign
ı.	Director		212 28 4572	☐M 2.23F	72	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Aug. 2	9, 19	32	Mary	yland	
	and w		Usuel Residence of Decedent  10a, State 10b, County		10c. Ci	ty, Town or Lo	cation							1	Od Inside	City Limits
	Manyl.	ō	Maryland Baltimo	re		Baltimo										es 21 No
	r 28e	rect	10e. Street and Number			DGTCIM	10f. Zip	Code				10g. Citize	an of Wh	at Coun	try?	
	th with	ai D	3913 Myrtle Av	enue				212	27			U	.S.			
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or iteme 23a or 28e-f ehow aumalic event, the Mariscal Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deceder Armed Force 1  Yes 2 If Yes, Give Year or Date:	s? No		Vas Deced I Yes, spec			gin? (Spe , Puerto	ecify Yes or No Rican, etc.)			White,		1
5-0036	2 hou atura cal E	ted	15. Decedent's Ed	ucation		16a. Deced	lent's Usua	l Occupa	tion			16b. Kind	of Busin	ness/Inc	Justry	
212	hin 7. B. Med	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4c	r 5+)		kind of won OO NOT us		uring most	of worki	ng		_			
7	ed wil	Con	9th	0,0		Home	maker					1	Own	Home	∋	
Maryland 2121	B la b ♥	To Be	17. Father's Name (First, Middle, Last) Frank	Schuck							(First, Middle ie Chor		umame)			
	1 and 2 shi Health and tem 27 is m		19a. Informant's Name/Relationship (7 James Collison			3913	Myrt1	e Av	enue		Altimor	-				7
Baltimore,	permit. Peges 1 and 2 should Department of Health and Men Importent: If Item 27 is marke eny injury or other treumatic 0068.		20a. Method of Disposition  1 3 Burial 2 Cremation 3   4 Donation 5 Other (Specify			Place of Dispo cemetery, cren dar Hi					2005	20c. Loca Balt:				and
Balti	permit. Peges Department of Important: If if eny injury or o		21. Signature of Funeral Service Licen.	"OA ne	las	22	. Name and	d Address	s of Facility	Go	nce Fu	neral	Ser	vice	, P.	Α.
9/e0, V	whysician and hysician al Examiner	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading or immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Fluid Due to (or a	as a consecutive strice	uence of):	cac	he	te ia	10	-bala	in ce			Interval B Onset an	onth onth	
O. Box 6	the death certific y the attending p ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 15 No 9 ☐ Unknown	23c. If yes, outcorr 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	Ideath 3	Ectopic pre					230	d. Date o Month		ry Day	Year
ds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions co	ntributing to death	but not res	ulting in the ur	iderlying ca	use givei	n in Part I.			obacco use Yes 2 🔀 i				
Hecords,	The ate h	Completed									24a. Was autor perfo 1  Yes	rmed?	prio	r to con	rpletion of	gs available cause of
VITal	ician: T certificat rector, pa	Be	25. Was case referred to medical examiner?	Jacobski.				_		of Death	(Check only o	ne)				
_	di	tion: To	27. Manner of Death  1 SNatural 5 Pending	Hospital: 1 Inpa 28a. Date of In (Month, D		ER/Outpation 28b. Time of Injury		c. Injury Work	4   1401	2	ne 5 Resid			(Spacify	Hosp:	ice
DIVISION	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of I building,	njury - At ho etc. (Specif	ome, farm, stre				-	28f. Location (5 City or Tox		√umber c	or Rural	Route Nu	ımber,
	ne Hospit n 24 hour ne Funere	Medical (	29a. Certifier 1. Certifying Phy (Check only one) 2 Medical Exami	sician: To the besiner: On the basis and manner:	of examina	wledge, death tion and/or inv	occurred a estigation,	t the time in my opi	e, date and nion, death	place, a	ind due to the ed at the time,	cause(s) an date and pl	id manne ace, and	er as sta	ited. the cause	e(s)
	To the To the comp	Ž	29b. Signature and title of certifier				29c.	License		_		29d. Date s				1
			· M	101	7			D	45.	271	1	May	19,	200	5	
	10		30. Name and address of person who ce Cho C. Maung, N					Sui	te 30	1 C	atonsvi	ille,	Mary	ylan	d 21	228
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 2. 4.21	32. Regis	trar's Signa	iture										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 11em 31 per dvr 8843 5-24-05 vt State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year RICHARD HOWARD CLARK MAY 19, 2005 7:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7753 SAUERBACKER RD. **PASADENA** ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral**  Birthplace (State or Foreign Country) 1□ M 2□ F Months Yrs. Director 58 <u>216.44.5485</u> MAR 13, 1947 MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2☐ No Director MD ANNE ARUNDEL <u>PASADENA</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or itams 23e or 7753 SAUERBACKER RD. 21122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2000 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Year or Dates: 1964-67 Specify: neturel WHITE ted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Comple I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) FIELD SERVICE REPRESENTATIVE MANUFACTURING 12 other permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If item 27 is marked othe any injury or other traumatic evant, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk DORIS CLARK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTY R. CLARK WIFE 7753 SAUERBACKER RD. PASADENA, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) VET CEM CROWNSVILLE 5.24.2005 MD CROWNSVILLE, MD Funeral Service Lice 22. Name and Address of Facility
FINK FUERAL HOME, P.A. necosin Rart1. Enter the disease, or combine shock, or heart failure. List only on 23a. Part1. 426 CRAIN HWY SW GLEN BURNIE, MD 21061 MO1148 ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Interval 8etween Onset and Death Immediate Cause (Final disease or condition resulting in death) Coroners **Physician** Arter /Medical Due to (or as a consequence of) Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit pesity U yer Due to (or as a consequence of); Box 68760. Physiclan/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month 4☐Pregnant at time of death Year 5 Other (specify) P.O. detached 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 KNo 3 Probably 4 Unknown page 2 should Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2 No Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. after death investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 124 hour. Two Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie completely (Check only one) within 2 To the

0

31. Date filed (Month, Day, Year) State MAY 2 4 2005 Registrar

29b. Signature and title of certifier

8

WID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

1)50254

29d. Date signed (Month, Day, Year)

			For State Registrar	State of M	aryland	•	artment			and M		jienę <sub>eg. Nö.</sub> ()	05	17375
	Physicia	an	Decedent's Name (First, Middle, La	st)							2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	Adam H. Coback				4h Cihi	Taura	l sastina a	f Dooth	MA.	<del></del>	unty of Death	
	Examin	er	4a. Fecility Name (If not institution, gives Saint Joseph		Cent	er	4b. City,	i own, or	Location o	OWS(	on	40.00	-	timore
	Funeral		Social Security Number 6.5	Sex 7. Ag	e (In yrs. las	t birthday)	If Under		If Under		8. Date of Birth	Vaasl	9. Birth	place (State or Foreign intry)
	Director		220-07-0466	I⊠M 2□F	82	Yrs.	Months	Days	Hours	Min.	(Month, Day Dec. 8		Mary	
	pur 🛊		Usual Residence of Decedent  10a. State 10b. County		10c. City, 1	Fown or Lo	cation							10d. Inside City Limits
	Marylis f sho	٥	Maryland Baltime	re			sville							1 ☐ Yes 2 🛣 No
	28e-	Director	10e. Street and Number	) <u> </u>		acons	10f. Zip				1	0g. Citizen	of What Cou	untry?
	ath with the Marylan 23e or 28e-f show	alD	404 Lee Drive					2122	28			U.:	S.A.	
	Items (	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Deced	ent of Hi	spanic Ori	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)		Race - Amer Black, White	
36	hours after death with the Maryland turel', or Items 23e or 28e-f show at Examiner hast be multipled at	by Fu	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 X Yes 2 I If Yes, Give Year or Dates:	NO WW II		1□Yes 2	No 🖾	Specify:			Sp	ecify:	ite
21215-0036	72 hours after de "neturel", or Items dical Examiner	edt	15. Decedent's E	ducation		16a. Dece	ient's Usua	I Occupa	ition			16b. Kind	of Business/l	
215	within 72 ene. than "nel	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)  College (1-4or	5+)	(Give life.	kind of wor DO NOT us	k done d e retired)	u <i>ring m</i> osi )	t of workii	ng			
21	be filed within 72 ha tal Hygiene. d other than "netu event, tre Madical	Con	11			Mail	Carr		45.44.4					1 Service
gu	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last								(First, Middle,		,	
Maryland	d 2 should be th and Mental 7 is marked o treumatic eve	은	Harrison Kabakol			19b. Mailir	ng Address	(Street a			ve Cho			ip Code)
Ma	atth a		Dorothy Szczuble	wski (Sis	ter)	7826	Gough	Str	eet	Bal	timore,	Mary.	land 2	1224
Je,	- I = =		20a. Method of Disposition	7D	20b. Plac	e of Dispo	sition (Nan	ne of ther place	9)	D	ate	20c. Locat	ion - City or 1	own, State
Ē	Pages ment of ant: If it ury or o		1 ☐ Burial 2 🖾 Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Special Control of		1		sh Cre			5-22	<b>-</b> 05	Laur	el, Ma	ryland
Baltimore,	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Lice	n ee		W:	Name an itzke 30 Ed	Fun	eral	Home	of Cat	onsvi ville	11e, I , MD 2	nc. 1228
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause one cause on each I	d the death. ine.	Do not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
5	Priysician	(7 - A	Immediate Cause (Final disease or condition resulting in death)	a. SEPSI	S									7 DAYS
	/Medical Examiner		resulting in dealth)	Due to (or as			FEIC	TIE	COL	TTIC				7 DAYS
	*	ē	Sequentially list conditions, if any, leading to immediate	b	a consequer		11144	t alle Steen Song	Seed Said Steen	2145	,			1 2711127
	outed id ansit	Examiner	d any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c										
ő	be executed sician and burial-transit	Ex	resulting in death) Last	Due to (or as	a conseque	nce of):								
8760,	ate be %	dical		d										
9 xo	death certifica attending pla of for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnanc							23d	. Date of deliv	/ery
BC	death e atter d for t	iciar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pr Other (sp						Month	Day Year
P.0		hys	9 Unknown	9□ Unknown										
	The law requires that the site has been signed by the page 2 should be detache	by	Part II. Other significant conditions	contributing to death t	out not resulti	ing in the u	nderlying c	ause give	n in Part I.	•	23e. Did to	~		the cause of death?
ord	w requir been si should	eted									8000000	/\		
Records,	has b	Completed									24a. Was a autops perfor	sy	prior to c death?	opsy findings available ompletion of cause of
Vital		ပိ	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes (Check only or	2 No	1 🗆 Yes	ZUN0
N S	Physicien: this certific ral director,	0 8	examiner? 1 Tyes 2 No	Hospital: 1 Inpati	ent 2□EF	 R/Outpatie	nt 3 DC	Othe			ne 5 Resid		Other (Spec	ify)
n of	ding Physicien: h. After this certific funeral director.	T :uo	27. Manner of Death 1 SNatural 5 □ Pending	28a. Date of Inj (Month, Da	ury 2	8b. Time o Injury	f 2	8c. Injury Work			28d. Describe h	ow injury o	ccurred	
Sio	Attending or death.	catle	2 Accident investigate 3 Suicide 6 Could not				M		Yes 2□		29f Location (C	troot and h	tumbor or Pu	ral Pauta Number
Division	l or At after o Direct	Certification:	4 ☐ Homicide determined	289. Place of in	jury - At hom tc. <i>(Specify)</i>	e, farm, st	reet, factory	, office		1	City or Tow		rumber or Au	ral Route Number,
_	Hospite 24 hours Funerel stely filled	edical C	29a. Certifier 1 Certifying P	hysician: To the best miner: On the basis of and manner s	of examination	edge, deat n and/or in	h occurred vestigation	at the tim	ne, date an pinion, dea	d place, a	and due to the dead at the time, o	ause(s) and late and pla	d manner as ace, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1			290	. License	number		2	29d. Date s	igned (Month	, Day, Year)
1	,_		· (1///	1_				D 5	8944			5/18	105	
	14		30. Name and address of person who	completed cause of	death (Item 2	3a) (Type,	Print)							
	8		CHRISTINE BOL	TZALE	nar's Signature	7601	_0SL	ER.	DRIV	E, 1	COWSON,	MAF	SALUMI	21204
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 2 4 2	005 Anegist	rar's Signatui	do	will							
	5.0			1-1-630										

Robert Lee Clay 05-3396 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. anend/unpend item/1, 23a, 27, 28a-f, pen/E, 3345, 7///05 TT

State of Maryland / Department of Health and Mental	Hygiene /	1
State of Maryland / Department of Health and Mental  Certificate of Death	Reg No	1

			1 - For State Registrar	Otato of marytand	Cen	tificate of		noman m	Reg. No.	)5	17376
	Physici		Decedent's Name (First, Middle, Last	Robert Lee Clay	T			2. Date of De Month May 1	eath Dav	Year	3. Time of Death 10:52 A M
	/Medio Examin		4a. Fecility Name (If not institution, give 2213 Brookfield Av	street and number)			r Location of Death		4c. County	of Death	10.52 11
	Funeral Director		5. Social Security Number 6. Se 2/5 -46-3499		t birthday)_ Yrs.	Baltimor If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	ay, Year)	9. Birthp Cour	place (State or Foreign htry) H Carolina
,	ie Maryłand 8e-f ehow utilied at	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Howard	, ,	own or Loc	ation				1	l0d. Inside City Limits
	h with th	al Dire	10e. Street and Number 9325 All Sail	ints Road		10f. Zip Code	2.3		10g. Citizen of	What Cour	itry?
980	tiges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heath and Mental Hygiene.  If Item 27 is marked other than "natural", or Items 23e or 28e-1 ehow or other treumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ① Ho If Yes, Give Year or Dates:			lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		ce - Americ ck, White, y: B/	etc.
21215-0036	vithin 72 ho ne. han "natur e Medicel I	Completed	15. Decedent's Edu (Specify only highest grad	completed) College (1-4or 5+)	(Give k life. D	O NOT use retired	during most of work	ting L	16b. Kind of B	,	
	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, the Na	To Be Co	17. Father's Name (First, Middle, Last)	ay Sr.	(50)	neral	18. Mother's Nam	e (First, Middle Harr	, Maiden Suman		AL
e, Maryland	1 and 2 should Health and Men em 27 is marke other treumatic	_	19a. Informant's Name/Relationship (Ty Gerietta Clay	Wife	9325	A115	and Number or Rur aints R	al Route Numb	er, City or Town,	UD -	20723
Baltimore,	Pe ant		20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)  21. Significant Fundal Service Ucers	MD/	Nemo	ition (Name of atory or other place Y I I Par Name and Address	K May.	25,2005	Laure	City or To	wn, State
Ba	permit. Departr Importe any inju		Minth	-177	Mil	Ver's Metr	apolitan (	hapel 19-		Dr. A	
	Physician /Medical Examiner		23a. Part Enter the disease, o compl shock, or fleat failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations had caused the death. It is cause on each line.  Contact Gunshot I  Due to (or as a consequent	Wound o		g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequen	ce of):						
68760,	icate be executed physician and s the burial-transit	Medical Ex	resulting in death) Last	Due to (or as a consequen	ce of):						
O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3□E	Ectopic pregnancy Other <i>(specify)</i>				te of delive	ory Day Year
ords, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions cor	atributing to death but not resultin	g in the und	derlying cause give	en in Part I.	23e. Did t	_,		ne cause of death? ably 4 □Unknown
al Records,		Completed						24a. Was auto perfo 1 2 Yes	ormed?	prior to cor death?	psy findings available npletion of cause of 2 \( \square\) No
of Vital	ng Physicien: Ter this certificanes and director, p	n: To Be	27. Manner of Death		Outpatient	3 DOA Othe	4   Nursing no	me 5□ Resi			at scene
Division	or Attendir ifter death. Director: Af in by the fui	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	May 16, 2005  28e. Place of Injury - At home building, etc. (Specify)	10:40	<b>P</b> M 1 🗆 .	Yes 2 ANo	Subject 28f. Location (. City or Ton Baltim	shot sel Street and Numb wn, State) 22 re. MD	f 13 Bro	Route Nymber, <b>ckfield Ave</b>
	To the Hospitel within 24 hours a To the Funeral ( completely filled	Medical (	29a. Certifier 1 Certifying Physical Contect only 2 Medical Exemination	sician: To the best of my knowled ner: On the basis of examination and manner stated.	dge, death and/or inve	occurred at the time stigation, in my op	ne, date and place, pinion, death occurr	and due to the	cause(s) and ma	nner as st and due to	ated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed		
		1	30. Name and address of person who co	mpleted cause of death (Item 23	a) (Type, P						

State Registrar

ANA 31. Date filed (Month, Day, Year) MAY 2 4 2005

KUBIO, MD

111 Penn Street Baltimore, Maryland 21201 2. Registrar's Signature Sperke

CAPIAN EUNIÉE 5/20/05 9:50 pm

Division of Vital Records, P.O. Box 68760,

		1 - For State Amend Item 20 Registrar	State of per	f Marylan fh G843	d / Depa 5-24- Ce	artment of H	lealth ai <i>Death</i>	nd Me	ntal Hyg	iene	105	173	77
Dhysia	ion	1. Decedent's Name (First, Middle, Last)					-	2	Date of Deat	h Day	Year	3. Time o	of Death
Physic /Medi		EUNICE				C	APLAN		MAY	,	2005	9:50	D M
Exami	ner	4a. Facility Name (If not institution, give:				4b. City, Town, or	r Location of	Death		4c. Co	unty of Death	3.50	
<b>-</b>		HOSPICE OF BALTI  5. Social Security Number  6. Security Number		7. Age (In yrs.		If Under 1 Year	TOV	VSON	Date of Righ		BALT	IMORE	
Funeral Director			м 2□Х	91	Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day, 7/27/1	Year)	9. Birth Cot	place (State intry)	
		Usual Residence of Decedent							11211	1713_		MD	,
nylan show	_	10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside C	,
Ba-f s	cto	MD BALTIMO	RE	BAI	LTIMOR	Ε						1 🗌 Yes	2 No
vith th	Director	10e. Street and Number				10f. Zip Code			10	0g. Citizer	of What Cou	intry?	
s 23s	rai	16 OLD COURT ROAI				21208				-	S.A.		
Item Item	Funerai	11. Marital Status 1 ★ Never Married 2 Married	Armed F		S.   13. 1	Was Decedent of Hi f Yes, specify Cuba	ispanic Origii an, Mexican, i	n? (Speci Puerto Ri	ty Yes or No- can, etc.)	14.	Race - Amer Black, White		
urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or D	ive		1□Yes 2X No	Specify:			Sp	ecity: WH	ITE	
If I I I I I I I I I I I I I I I I I I	Completed	15. Decedent's Edu			16a. Dece	ient's Usual Occupa	ation			16b. Kind	of Business/li	ndustry	
Ithin ithin	npie	(Specify only highest grade Elementary/Secondary (0-12)		1-4or 5+)		kind of work done of OO NOT use retired	during most d d)	or working					
ygien Ygien t, th	S	12			BOOK	KEEPING				BUL	IDERS		
be fill Hall H	Be	17. Father's Name (First, Middle, Last)		0.4.0.4					First, Middle, N				
d 2 should be filed within hand Mental Hygiene. 7 Is marked other than "traumatic event, traumatic	2	MORRIS	an Drivat	CAPI		444 (2)	SARAL				CHASEN	-	
d 2 st d 2 st th and th and traur		19a. Informant's Name/Relationship (Ty)  CATHY COHEN / COI	JSIN			g Address (Street a						p Code)	
permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Example are must be notified at once.		20a. Method of Disposition	)J1N	20b. P	lace of Dispo	sition (Name of	ī	Dat	NGTON,		ion - City or T	own State	
ages ant of tt: If it		1 Burial 2 Cremation 3 R	emoval from	State	emetery, cren	MUNO other place	(e)						
nit. P artme orten injur	10	21. Signature of Funeral Service License	18	CH.		HNO CONG. Name and Address		5/23/			IMORE,		
permi Depa Impo any ir	1 5	1 Routo 12		$\supset$		000 REIST							กร
		23a. Part1. Enler the disease, or compli shock, or heart failure. List only on	cations that	caused the death							1666	Approximat	te
Physician		Immediate Cause (Final	e cause on a	ACUT	0 <	roke						Interval Bet Onset and	Death
/Medical		disease or condition resulting in death)	Due to	(or as a consequ		11026						O. A.)	75
Examiner		Sequentially list conditions, b											
p #	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequ	ianes of):								
and -trans	cam	that initiated events resulting in death) Last	Dun to	(or as a consequ									
cate be executed physician and the burial-transit			Oue to	(or as a consequ	ience or):								
phy the	dical	d											
The law requires that the death certification is a second to the law requires that the death certification is a second be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, ou	tcome of pregnar	ncy					224	Date of delive		
death a atter	ciar	in the past 12 months?	1 Live t	oirth 2 ☐ Fetal nant at time of de	death 3	Ectopic pregnancy Other (specify)				230.	Date of deliv Month	•	Year
at the de by the de	hys	9 Unknown	9□ Unkn	own		***							
es tha gned b	by P	Part II. Other significant conditions con	tributing to d	eath but not resu	ilting in the ym				23e. Did toba	acco use o	contribute to t	he cause of c	leath?
w require been sig		Acute myo	CIAV	dial	int	Avetic	M		1 ☐ Yes	s 2 <b>2</b> N	o 3∏Prol	oably 4 🗀 l	Jnknown
e law re has be	ompieted	ityperten	Sin	1					24a. Was an		4b. Were auto	psy findings	available
	Com	/ /						_	autopsy perform		death?	mpletion of c 2∏ No	ause or
Physicien: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?					26. Place of	f Death (C	hack only one				
Physic this o	은	1 □ Yes 2 No	-		ER/Outpatient		4 🗀 Nursi	ing Home	5 Residen	nce 6	Other (Specia	y Hosp	ice
	ion:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. Injury Work	.?		l. Describe how	v injury oc	curred		
Attending in death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	One Diese	of lains. At La			res 2⊡No		1				
or A efter Direction by	Certification:	4 ☐ Homicide determined	build	or injury - At noting, etc. (Specify	me, tarm, stre	et, factory, office		281.	Location (Stre City or Town,	set and Nu State)	imber or Rura	al Route Num	ber,
spital ours neral filled		29a. Certifier 1 Certifying Phys	icien: To the	best of my know	viedne death	Occurred at the tim	e date and r	alace and	due to the car	uso(s) and	I mannar ac a	tated	
124 h	edicai	(Check only 2 Medicel Exeminone)	er: On the b	asis of examinati ner stated.	ion and/or inv	estigation, in my op	oinion, death	occurred	at the time, dat	te and pla	ce, and due to	the cause(s	:)
To the Hospital or Attendin within 24 hours elter death. To the Funetal Director: Aft completely filled in by the fur	Me	29b. Signature and title of certifier		1.0		29c. License	number		29	d. Date siç	gned (Month,	Day, Year)	
		> W Hust	uny	Meley	i c my	1 02	2399	5	1	MA	72	1,200	25
7		30. Name and address of person who con	npleted aus	se of death liem	23а) (Туре, Р	Print)		66	01 N. (	Char1	es Str	eet	
		W.A. Rila	7						wson, M				
Sta Registr		31. Date filed (Month, Day, Year)  MAY 2 4		legistrar's Signat	ure	hand .			-				
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Joyce Dale 05-03385

## Plea

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State of Manuand / Do					-

N	JM		1 - For State Registrar	State of M	aryland / Dep	artment of H		Mental Hy	giene	15	17378	3
	Physic /Medi		1. Decedent's Name (First, Middle, Joyce	Lee Dale				2. Date of De Month MaV		Year 2005	3. Time of Dea	ith N
	Exami		4a. Facility Name (If not institution,			4b. City, Town, o	r Location of Deat			nty of Death	10140	
	Funeval		1906 Charleston 5. Social Security Number		ge (In yrs. last birthday)	Hyattsv If Under 1 Year		. 8. Date of Bir			George's	
	Funeral Director		249-44-3502	1□M 2⊠F	73 Yrs.	Months Days	Hours Min.		av. Year)	Cour	place (State or For ntry) h Caroli	
	and w.		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation	-	1 8				
	Maryl -f sho	to	,	e Georges		tsville				1	0d. Inside City Lin 1 ☑ Yes 2 ☐	
	th the or 288 k noti	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Cour	ntry?	
	s 23a	ral	1905 Charlest				783			S.A.		
036	urs after de al', or itam Examiner n	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marrie  3 ➡ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? d 1 □Yes 2X If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No to Rican, etc.)		ace - Americ lack, White, cify: Whi	etc.	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itams 23e or 28a-1 show any highly or other traumatic event, the Medical Evantil are mast be rigilled at ance.	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)  College (1-4or the second college)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of wor	rking	16b. Kind of		lustry	
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an	should be ind Mental I	To Be	Jesse H.	•				ie Brag		ame)		
a <sub>Z</sub>	2 should and N is mar	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numbe	er, City or Tow	n, State, Zip	Code)	
	ealth fealth im 27 her tra		David Cato-	Personal	Rep 9222	Columbia	blvd Si					
Baltimore,	Pages nent of h		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	☐Removal from State	1	natory or other plac	1	Date	20c. Location			
	permit. P Departme Importan any injury once.		* 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Se vice Lice	W-0416	Fort Line	. Name and Addres			Brent			_
ñ —	Depar Impo any ir		1			8401 Blad						
	/Medical Examiner the prize transit the prize transit the prize transit the prize transit tran	Examiner	23a. Part1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Squantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Smoke Due to (or as	a consequence of):  a consequence of):	ard flur	malinium	ry compli	entij Alex	xdoro T:	Approximate Interval Batween Onset and Death	
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. Box c	death certiff e attending od for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 → No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)				ate of deliver	ry Day Year	
cords, r	w requires that the been signed by th should be detache	by	Part II. Other significant conditions	contributing to death be	ut not resulting in the un	derlying cause give	en in Part I.		obacco use cor ′es 2⊠No		e cause of death?	
nec	The law ate has b page 2 s	Completed								prior to com death?	sy findings availa apletion of cause of	ble of
VICA	Physiclan: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  12€ Yes 2 □ No	Hospital:	_	3CI DOA Othe	26. Place of Deat				7-1	
	ding h. After fune	-	27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	28a. Date of Injur (Month, Day	y 28b. Time of Injury	28c. Injury Work	4   Nursing Ho	ome 5 ☐ Resid 28d. Describe h	ow injury occu	rred O.	Scene	
	lo the Hospital or Attanding within 24 hours after death.  To tha Funaral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not determine	-1/6/03	ury - At home, farm, stre	-		28f. Location (S City or Tow	n, State) 190	6 Chan	Route Number, Leston Pl PS.Co H	- D
	the Hospi nin 24 hou tha Funar npletely fill	edical	one)	Physician: To the best of aminer: On the basis of and manner sta	examination and/or inv	occurred at the timestigation, in my op	e date and place	and due to the o	alica(c) and m	annor ac eta	tod	
1	0 1 ₹ °	Σ	29b. Signature and title of certifier	hy M	\	29c. License OCM	number E		May, 16			
	10		30. Name and address of person who so that the sound is a sound in the sound in the sound is a sound in the sound in the sound is a sound in the sound is a sound in the sound in the sound is a sound in the	in 17		Ti Penn	Street I	Baltimor	e, Mar	yland	21201	
21.14	Star Registra	ar	MAY 2 4 20	005 Hegistra	r's Signature	W						
	H 17 Rev 1/20	111		-	-							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Mary		rtment of H tificate of L			ene () () 5	17379
	Physici		Decedent's Name (First, Middle, MICHAEL	JOSEPH	DELVEC	CHIO		2. Date of Death MAY 20,	Day 2005	3. Time of Death  5:01 A M
ı	/Medic Examin		4a. Facility Name (If not institution, GILCHRIST HOSP	•		•	Location of Death		4c. County of De	
	Funeral Director		218-28-8457	6. Sex 7. Age (In 1	n yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 8-1-19	9. Bi 34 M	rthplace (State or Foreign Country) ARYLAND
	yland		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	cation				10d. fnside City Limits
	he Mar 28a-1 si	Director		BALTIMORE		Tion on a second	ROSEDA			1 ☐ Yes 2 XNo
	h with t	ai Dir	10e. Street and Number 8113 SAGRAMORE	ROAD		10f. Zip Code 21	1237	10	og. Citizen of What C $U_{ullet}$	country? S.A.
036	J within 72 hours after death with the Maryland jiene. It han antural, or items 23s or 28s-f show It han Jacal Exaryline must be nullied at	by Funerai	11. Marital Status  1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced			Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
5-0036	72 hou	eted	15. Decedent's (Specify only highest		16a. Deced	ent's Usual Occupa kind of work done of OO NOT use retired	ation furing most of work	sing 1	6b. Kind of Busines	s/Industry
1212		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		RICKLAYET				UNION
Maryland 2	ould be filed Mental Hygis arked other atic event.	To Be C	17. Father's Name (First, Middle, L JOSEPH	ast) DELVECCHIO				e (First, Middle, M LTA	laiden Sumame) (ROMEO)	
	s 1 and 2 should t f Health and Ment Item 27 is marked other traumatic		19a. Informant's Name/Relationshi			g Address (Street a		al Route Number,	City or Town, State, VER, MD	Zip Code) 21220
saltimore,			20a. Method of Disposition 1√2 Burial 2 □ Cremation	3 Removal from State	-	atory or other place	9)		0c. Location - City o	
altin	permit. Page Department of Important: if any injury or once.		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L		GARDENS O				BALTIMORI ALE FUNER	
ñ	Pe d L		- Sa	Uto	12	11 CHESAC	O AVENUE	ROSED	ALE, MD	21237
5	Pnysician		23a. Part1. Enter the disease, or of shock, or heart failure. List of firmediate Cause (Final disease or condition	complications that caused the nly one cause on each line.	1	r the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):					0
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a co	onsequence of):					
ń	cate be executed physicien and the burial-transit	Examin	that initiated events resulting in death) Last	cDue to (or as a co	onsequence of):					
8/60	cate be ohysicie the bur	dicai		d						
ň	death certifi e attending I d for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
cords, P.	requires that the een signed by th hould be detache	by P	Part II. Other significant condition	s contributing to death but no	ot resulting in the un	derlying cause give	n in Part I.	23e. Did toba		o the cause of death?
Lec	The tar ate has page 2	Completed						24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
VItal	certifi ector	o Be	25. Was case referred to medical examiner?	Hospital:		2C DOA Othe		h (Check only one		
VISION OF	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.	ertification; To	1 Yes 25 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day Ye.	2 ER/Outpatient 28b. Time of Injury	28c. Injury Work	at	me 5 ☐ Residen 28d. Describe how		Hospice
	tal or Atters as after de al Directo	Certific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		At home, farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	the Hospi in 24 hour the Funer pletely fill	edical	29a. Certifier 1 Certifying (Check only one) 1 Medical E	Physician: To the best of my xaminer: On the basis of exa and manner stated.	y knowledge, death imination and/or inv	occurred at the time estigation, in my op	e, date and place, inion, death occurr	and due to the cau red at the time, dat	ise(s) and manner as e and place, and due	s stated. e to the cause(s)
	To T com	Σ	29b. Signature and title of certifier	M. C.	lu, n	29c. License	number		d. Date signed (Moni	
	1.	ŀ	30. Name and address of person w	ho completed cause of death		195			MAY 20, arles Str	
	Q		31. Date filed (Month, Day, Year)	ey				wson, MD		
	Sta Registr	_	MAY 2 4 20	105	Signature Speed	es es				

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Communication of the Property of the Index of the

		For State of Maryland / Department of Health and 1- State Amend Item 4c&Unpend Item 23a 27 28a-f per me G& Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of D	1109.110.	J	3. Time of Death
Physici /Medic		MICHAEL ALAN DOUGLASS	MAY 20	Day 2005	Year	6:55 P
Examir		4a. Facility Name (Knot institution, give street and number) 4b. City, Town, or Location of De	ath	4c. Coun	ty of Death	
Funeral		1732 BATARD AVE  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	rs. 8 Date of B		IMORE	
Funeral Director		216-68-2983 17 M 2□F 49 Yrs. Months Days Hours M Usual Residence of Decedent		956	MAR	lace (State or Foreig try) YLAND
the Maryland 28a-f show	Director	10a. State MD 10b. County BALTIMORE 10c. City, Town or Location DUNDALK			1	0d. Inside City Limit 1 ☐ Yes 2X N
th with th 23a or 26 ust be no	al Dire	10e. Street and Number 10f. Zip Code 21222		10g. Citizen of	What Coun	-
er dea Items	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Zivo Yes, Givo Yes, Givo Yes or Dates:  13. Was Decedent of Hispanic Origin?  14. Yes Decedent Ever in U.S. Armed Forces?  15. Was Decedent of Hispanic Origin?  15. Was Decedent of Hispanic Origin?	(Specify Yes or N erto Rican, etc.)	o- 14. Ra Bl:	ice - Americ ack, White,	an Indian,
Z I Z I 3-0U35 ad within 72 hours aft glene. er than "natural", or if e Madical Exami	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  PTP: FTTTEP	rorking	16b. Kind of I	Busine <i>s</i> s/Inc	dustry
TG Z IZ e filed withi al Hygiene. lother than vent, IT e.M						SMISSION
ed ala	To Be	17. Father's Name (First, Middle, Last)  CHARLES  DOUGLASS  18. Mother's N  JOA	ame <i>(First, Middl</i> e N	a, Maiden Suma	<sub>тө)</sub> ( ТЕА	AL)
Maryle d 2 should th and Mer T is marke traumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or I	Rural Route Numb	er, City or Town		
C, IV	1 8	NANCY DOUGLASS/ WIFE 1732 BAYARD AVENUE  20a. Method of Disposition   20b. Place of Disposition (Name of		LK, MD	2122	
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		1 Burisl 2-Cramation 3 Demoval from State   cemetery, crematory or other place)	Date -24-2005	20c. Location		
Dermit. Depart Import any inj		21. Signature of Funeral Service Licensee  22. Name and Address of Facility C  1211 CHESACO AVE		EDALE FO SEDALE,		HOME 21237
5		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi shock, or heart failure. List only one cause on each line.				Approximate Interval Between
Itilicate be executed  /Medical Examiner  as the burial-transit  as the burial-transit	cal Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Morphine and Oxycodone Intoxication Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	JII			
	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   5   Other (specify)   9   Unknown   5   Other (specify)   1   The state of t			ite of deliver	y Day Year
w requires that sheet should be detailed to		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				cause of death?
40 CD 42	e Completed	25. Was case referred to medical 26 Place of D	1 Nes	osy ormed? 2 \( \text{No} \)	Were autop prior to com death. 1 Yes 2	sy findings available pletion of cause of
ysicia is cert directe	To B	examiner?	eath <i>(Check only o</i> Home 5 Resid		or (Conside)	CCENT
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:	ation:	27. Manner of Death  1 Natural 5 Pending Investigation 2 a. Date of Injury Year)  2 Accident Townstigation 5 2 0 0 0 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		how injury occur		SCENE unk
ital or Att rrs after de ral Direct	Certification:	3 Suicide 4 Homicide  A Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  Found at home	Dundalk,	, Ma	2 Bay	ard Ave.
e Hospital 24 hours e Funeral l	edical	29a. Certifier  (Check only one)  (Check one)  (Check one	e, and due to the urred at the time,	cause(s) and ma date and place,	anner as sta and due to t	ted. he cause(s)
To the within 2 To the comple		29b. Signature and title of certifier  OCME  29c. License number  OCME		29d. Date signe MAY 21		* '
	ļ	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MANGEMENT D. KORE 111 Penn Street	et Balti	more, M	arylaı	nd 21201
Star Registra		31. Date filed (Month, Day, Year)  MAY 2 4 2005  32. Registrar's Signature				

			1 - For State Registrer	State of Ma	aryland / Dep <i>Ce</i>	artmen			and M	-	giene Reg. No.	05	17381
			1. Decedent's Name (First, Middle, Last	)						2. Date of De	ath		3. Time of Death
ı	Physici /Medio		Wilma Kathryn N	Weinrich	Dutton					Month May 20,	Day 2005	Year	11:00A M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of				nty of Death	
			14917 Bauer Driv	2		Roo	ckvi	11e			Mont	gomer	У
	Funeral		5. Social Security Number 6. Se		e (In yrs. last birthday	) If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th v Year)	9. Birth	place (State or Foreign intry)
ш	Director		477 40 0139	JM ŻŒF	101 Yrs.			Hours		Jan. 22	1904	Iow	
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation							10d. Inside City Limits
	Aaryl f sho	5	Maryland Montgome	rv	Rockvill								1 ☐ Yes 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
	28a-	Director	10e. Street and Number			10f. Žip	Code	<del> </del>			10g. Citizen	of 14/h on Oo	
	with Ba or		14917 Bauer Drive				0853						1
	death	Funerai	11. Marital Status	12. Was Decedent I	Ever in U.S. 13.			spanic Orig	zin? (Spe	ecify Yes or No		d Sta	
മ	or Iter		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕱 N	10			n, Mexican,	, Puerto	ecify Yes or No Rican, etc.)	E	Black, White	
ğ	ral', c	b	3 ∰Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	2 X No	Specify:			Spe	city: Wh	ite
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or flems 23e or 28e-f show ant, the Michael Examinat must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	edent's Usua kind of wor	l Occupa	ition	of works	ing	16b. Kind of	Business/Ir	ndustry
7	ithin Ban .	ğ	Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT us	e retired)	)	Or WORK	119			
	led w lygier her tl		12		Hom	emaker						Home	
and	be fi	Be	17. Father's Name (First, Middle, Last) Herman Richard We	o d 1						First, Middle,			
3	1 Mer narke	To			1100000					Barbara			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any figury or other traumatic event, the Modical Examinet must be notified at once.		19a. Informant's Name/Relationship (Ty  Dorothy Louise Dut							kville,			o Code) 20853
	1 an Heali em 2 ther		20a. Method of Disposition	COII/ Daugi	20b. Place of Dispo			LIVE,		Date	20c. Locatio		
Baltimore,	ages nt of t: If It		1 ☑ Burial 2 ☑ Cremation 3 □ F	lemoval from State	cemetery, cre	matory or ot	her place	· .		1.1			
턆	artme ortani njur)		4 ☐ Donation S ☐ Other (Specify) 21. Signature S Puneral Service License		Forest Ho				200	2			t, Iowa
Ba	permi Depa Impo any is		1/0//>1		100877 R	bert"	A. P	umphir	ey :	Funeral	Home/	Rockv:	ille, Inc.
			23a. Part 1. Enter the disease, or compl	cations that caused	the death. Do not en	JU Wes ter the mode	of dvino	ntgom	nery cardiac c	Avenue	, Rock	ville	MD 20850 Approximate
			Immediate Cause (Final	ne cause on each lin	e.		, ,			,			Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		Stage Deme	entia							
Ю	Examiner			•	a consequence ory.								
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		consequence of):								in the second
4	cuted nd ransi	Examiner	that initiated events										
Ö,	e exe ian a urial-t	Ë	resulting in death) Last	Due to (or as a	a consequence of);								
8760,	icate be executed physician and s the burial-transit	dical											
9	entific ling p	Med	IF FEMALE:				-						
Вох	ath co	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth	2 ☐Fetal death 3 ☐	⊒Ectopic pre						Date of delive Month	
0	the a	/sic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (spe	city)				,	VIOLITI	Day Year
<u>a</u>	The law requires that the death certify the has been signed by the attending to age 2 should be detached for use as	by Physician/Me	Part II. Other significant conditions cor	tributing to death bu	it not resulting in the u	nderhing ca	LISA GIVA	o in Part I		23e Did to	pacco use co	entributo to t	he cause of death?
Records,	signe d be		Acute Myo			riderly lig ca	usa givai	II III r ait i.		1 □ Y	v		pably 4 Dunknown
Ö	read	Completed								-			
že	has has	d E								24a. Was autop	sy	b. Were auto prior to co death?	psy findings available mpletion of cause of
	icien: The certificate ha										2□No	1 Yes	2 🕅 No
Vital	sicien: certific rector.	Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:			1			Check only or			
o	Phys r this aral di	2	27. Manner of Death	1 Inpatier			c. Injury	4 ∐ Nurs		ne 5 AResid			y)
on	nding Phi th. : After thi s funeral	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	М	Work?	? es 2 □ No			,,	a,, oa	
Division of	Atten ar deat actor: by the	ifice	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At home, farm, str	eet, factory,	office		2	28f. Location (S	treet and Nun	n <i>ber</i> or Rura	il Route Number,
	s afte	Certification:	4   Hornicide	building, etc	. (Ѕресіту)					City or Tow	n, State)		
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director. F.		29a. Certifier (Check only / Medical Examin	icien: To the best o	f my knowledge, deatle examination and/or in	h occurred a	t the time	e, date and	place, a	ind due to the o	ause(s) and r	manner as s	tated.
	the H in 24 the Fi plete	Medical	one)	and manner state	examination and/or in	vestigation, i	in my opi	nion, death	occurre	ed at the time, o	late and place	e, and due to	the cause(s)
	To To To To To To To To To To To To To T	2	29b. Signature and title of certifier		)	29c.	License	number	0	1 2	9d. Date sign	ned (Month,	Day, Year)
	80		4 Chill	CC			1)	4.1	21	8	5/2	0/0	5
	W		30. Name and address of person who co			,							
			Charles Harrison, 31. Date filed (Month, Day, Year)		)1 Muncast	er Mil	.1 Rd	i., Ro	ockv	ille, M	arylan	d 208	55-1622
	Sta Rogistr	- 3	MAY 2.4 200	5 Anneyistra	Le d								

ľ	Ш		State of Maryland / Departm State of Maryland / Departm State of Maryland / Departm Amend Items 4,a,b,c, 24a per filled	nent of Health and M 246 01 1964 174 105		ne 1005	17382
ı	Physici	an	1. Decedent's Name (First, Middle, Last)  LINDA M. DAVIS			Day Year	3. Time of Death M
	/Medic Examir			City, Town, or Location of Death	APRIL	2/ 200 4c. County of Dea	
	LXamii	ici	Howard County General Hospital	Columbia		Howard	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	Inder 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye		thplace (State or Foreign
	Director		482-60-9521 TO Yrs. Usual Residence of Decedent		10/01/4		ster City, I
	yland Iow		10a. State 10b. County 10c. City, Town or Location	)			10d. Inside City Limits
	a-fsh	ctor	MD Howard Columbia				1 □Yes 2 🔀 No
	th with the 23a or 28 Lat be not	ai Director		f. Zip Code 21044	_	Citizen of What Co Jnited St	,
980	y within 72 hours after death with the Maryland jiene. r than "natural", or Itams 23a or 28a-f show Ita Mydicul Evantrer must be notified at	by Funeral	Armed Forces? If Yes,  1 □ Never Married 2 □ Married 1 □ Yes 2 ₹ No	Decedent of Hispanic Origin? (Spe specify Cuban, Mexican, Puerto F es 21 No Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
Maryland 21215-0036	within 72 horens. ene. then "neture	Completed	(Specify only highest grade completed) (Give kind of life. DO No.	Usual Occupation of work done during most of workir of use retired)	ng 16b	Kind of Business	•
<b>d</b> 2	Hyge Hyge		17. Father's Name (First, Middle, Last)		(First, Middle, Maid	Howard C	ounty Hosp.
rylan	d be enta ked ced	To Be	Leroy Davis  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Add	Wanda H	arrington	)	
	Tra Tra		Chelsea Nixon Williams Daughter 8233 W	dress (Street and Number or Rura.  ellington Place	l Houte Number, Cil	MD 2070/	Zip Code)
Baltimore,			20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition cemetery, crematory	(Name of D		. Location - City or	
Ĕ	Pag Iment tant: I		`4 Donation 5 Other (Specify) Howard Medi	cal School 4/V/		Washingt	on, DC
Ball	permit. Pages 1 Department of H Important: If its any injury or ot		21. Signature of Funeral Service Licensee ANS 382	tTh^troystem Fun 1 14th St. NW W	eral Home ashington	DC 20	011
	Physician /Medical		23a. Part1. Enter the disease, of complications that caused the death. Do not enter the shock, or hear failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  A ESPIRATORY  A Complete the disease of condition as a condition resulting in death)	mode of dying, such as cardiac or	r respiratory arrest,		Approximate Interval Between Onset and Death
	Examiner	_	Bue to (or as a consequence of):	Veemod is			OHS
8760,	cate be executed physician and the burial-transit	dicai Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  **Due to (or as a consequence of):  Due to (or as a consequence of):  d.	?o enoon.JE 4	oleNo€42	محده المدت	WEEKS
.O. Box 68	death certifi e attending i id for use as	Physician/Med		oic pregnancy r (specify)		23d. Date of del Month	ivery Day Year
rds, P	sign d be	by	Part II. Other significant conditions contributing to death but not resulting in the underlying for 601. in Concordant Accident	ng cause given in Part I.	23e. Did tobacc		the cause of death?
al Records,		Completed			24a. Was an autopsy performed'	? prior to death?	topsy findings available completion of cause of 2 No
Vital	Physician: The this certificate al director, pages	o Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death			
of		-	27. Manner of Death  Adatural 5 Pending   28a. Date of Injury (Month, Day Year)   28b. Time of Injury	28c. Injury at Work?	ne 5 Residence 8d. Describe how in		cify)
Division	I or Attanding after death. Diractor: Aftel I in by the fune	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 4 Homicide 4 See. Place of Injury - At home, farm, street, far building, etc. (Specify)	1 Yes 2 No	8f. Location (Street City or Town, Sta		Iral Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	ical C	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occur of the basis of examination and/or investigation and one of the basis of examination and/or investigation and one of the basis of examination and or investigation and one of the basis of examination and or investigation and one of the basis of examination and or investigation and or inve	ition, in my opinion, death occurre	d at the time, date a	and place, and due	to the cause(s)
	within To the	Me	29b. Signature and title of cartifier	29c. License number	29d. [	Date signed (Monti	n, Day, Year)
			) UXXX	022856	A	m.2 22	2005
_			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ATLIK OF PLUT,	Clemba,	ml 2604	4
	Sta Registr	te ar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Rean  31. Date filed (Month, Day, Year)  MAY 2 4 2005  A graph of the control of the completed cause of death (Item 23a) (Type, Print)  32. Registrar's Signature  MAY 2 4 2005	V			

			Please  1 - For State Registrar		nt in Black in aryland / Dep <i>Ce</i>		ealth and Mer		<b>2</b> 005 17383
	Physici /Medic		1. Decedent's Name (First, Middle, L Marie H.				2.	Date of Death Month 5	Year 3. Time of Death
	Examin Funeral		44 Fecility Name (If not institution, g 45 Social Security Number 6. 578-62-5241	Center	ge (In yrs. last birthday, 92 Yrs.	4b City, Town, or the City of	inste	Date of Birth (Month, Day, Year larch 29,	9. Birthplace (State or Foreign Country) 1913 Wash. D.C.
	Director s t show	or	Usual Residence of Decedent  10a. State  10b. County  Md. Baltimo		10c. City, Town or L	ocation	17	lai ch 27,	10d. Inside City Limits 1 ☐ Yes 2 ☒No
	n with the	al Director	10e. Street and Number	Brook Cir		10f. Zip Code 21136		10g. C	Citizen of What Country?
920	permil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic evant, it is Marchal Exalting in until be notified at once.	Completed by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ∰ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces  1  Yes 2  If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 🗶 No	panic Origin? (Specify, Mexican, Puerto Rica Specify:	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036	s within 72 ho piene. r than "natur ir Med Call	ompleted	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education trade completed) College (1-4or	16a. Dece (Give life.	edent's Usual Occupat e kind of work done du DO NOT use retired) Housewife		16b.	Kind of Business/Industry  Homemaker
Maryland 2	2 should be filed withir and Mental Hygiene. is merkad othar than raumatic evant, Ite M.	To Be C	17. Father's Name (First, Middle, La George Her	bert				Maddox	<u></u>
, Mar	and 2 sho ealth and m 27 is m		David Daley -		2016	Ramblewoo	d Ave., Co	olumbus,	
Baltimore,	Pages 1 ment of H ant; if ital		20a. Method of Disposition  1	cify)		matory or other place Heaven Cem		2005 Si.I	Location - City or Town, State Lver Spring, Md.
Balt	permil. Departi Importi any inj		21. Signature of Furrera Service Lic	had t			uneral Cha		21117 ngs Mills, Md.
√60, ≪	Physician //Medical Examiner as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or or shock, or heart failure. List or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, in any least resulting cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. At the control of	s a consequence of):	ilii ma	llat	Pion	Approximate Interval Between Onset and Death
P.O. Box (	Attending Physician: The law requires that the death certificate redeath. ector: After this certificate has been signed by the attending physicator: After this certificate as been signed by the funeral director, page 2 should be detached for use as the	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delivery Month Day Year
ds, P	luires that n signed b ud be deta	by	Part II. Other significant condition	s contributing to death	but not resulting in the	underlying cause give	n in Part I.		o use contribute to the cause of death?  2 No 3 Probably 4 Unknown
of Vital Records,	: The law require cate has been si page 2 should I	Completed						24a. Was an autopsy performed 1 Yes 2	
n of Vita	ng Physician: The fler this certificate ha	on; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending	Hospital: 1 Inpat 28a. Date of Inj (Month, D	ury 28b. Time	of 28c. Injury Work	at 28d		6 □Other (Specify) jury occurred
Division	To tha Hospital or Attending Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	be 28e. Place of Ir	njury - At home, farm, s etc. (Specify)		'es 2 □ No 28f.	Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
J	To the Hospital or Atten within 24 hours after deat To the Funaral Director: completely filled in by the	dical Ce	29a. Certifier (Check only one) Certifying 2 Medical Ex	Physician: To the bestaminer: On the basis and manner s	of examination and/or i	ath occurred at the time	e, date and place, and inion, death occurred	due to the cause at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	To tha within 2 To the complet	Me	29b. Signature and title of certifier	Leon	87	29c. License	number )(p23-	301 <sup>29d. t</sup>	Date Rigned (Month, Day, Year)
arx	φ	4	30. Type and addres 12 (son w	go completed cause of	ath (Item 23a) (Type	rstel ()	larvell He	spital 1	Center)
	٥	ate rar	31. Date filed (Month, Day, Year)	32. Regis	trar's Signature	Sparke		1	,

amend item#5, perFH, G844, 6/6/05 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** 6:30 PM 19 May Geraldine, B, Ennis 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medical Center Mercy Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. 03 25 39 5. Social Security Number 7494 Birthplace (State or Foreign Country)
 MD 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F Months Yrs. Director 66 3-32 -6639Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 27 is marked other then "naturel", or Items 23e or 28e-f show treumetic event, the Medical Examir et must be notified at XXYes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1400 East Madison Street Apt 308 21205 U.S.A. Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify XWidowed 4 □ Divorced Black 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant Nursing Home 9th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ould be 1 is marked o Pages 1 and 2 should be ment of Health and Mentationt: If item 27 is marked Sophia Smith Alstine B. Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2943 Matthew Street, Baltimore, Md 21218 Edward Donald English-Son other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 5/25/05 any injury once. Arbutus Memorial Arbutus, Md 21. Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) NON - Small cell lung 3 months cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate have for the sequence of the sequen b Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-tran the attending physician and hed for use as the burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 2 cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 2 000 1 ☐ Yes or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel C 29a. Certifier TECertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 19 13112 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ryan McCormack Street, Suite 280, Baltimore, MD 21201 419 West Reduced

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) MAY 2 4 2005

32 Registrar's Signature

			1 - For State of Maryland / Dep	artment of Health and Martificate of Death	Mental Hygie	11115 1/300
	Dhamini		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Yeer 3. Time of Death
	Physicia /Medic		JEAN KATHRYN EINBROD			9, 2005 6:45 A. <sup>M</sup>
	Examin	er	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	·	4c. County of Death
			Brighton Gardens  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Towson If Under 1 Year   If Under 24 Hrs.	9 Date of Birth	Baltimore
	Funeral Director		218-26-5556	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye March 21,	9. Birthplace (State or Foreign Country) 1928 Maryland
р			Usuel Residence of Decedent		raccii 21,	1920 IMITYTANA
nylan	how		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
e Ma	Ba-1 s	cto	Maryland Baltimore Towson			1 ☐ Yes 2 No
with th	be n	Die	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
eath y	19 23,	erai	6451 N. Charles Street  11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sr	pacify Vas or No-	U.S.A.
G KIKID-UUSO tiled within 72 hours after death with the Maryland	i Health and Mental hygene. It neath and Mental hygene. Item 27 is marked other than "natural", or iteme 23a or 28a-1 show other traumatic event. The Medical Examiner must be multified at	by Funeral Directo	1 Never Married 2 Married 1 Yes 2 MNo If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ▼ No Specify:	Rican, etc.)	Black, White, etc.  Specify: White
- 6 - 6 - 6	natur Ileal	ted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv.	edent's Usual Occupation a kind of work done during most of work	king 16b	. Kind of Business/Industry
ithin .	Jan 1	Completed by	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	, and	
7 % P	her th		12 years	Secretary	- (Fire A 6) delle A 6 -	Medical
d be fil	ed ot	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	·
arylan should be	d Me mark matic	င္	Clinton Bruce Earnest  19a. Informant's Name/Relationship (Type, Print)  19b. Mail	Kathry Ing Address (Street and Number or Ru.		Griffin
, <b>Ma</b>	Ith an				enix, Mary	7821
5 - g	item (		20a. Method of Disposition 20b. Place of Disp			Land 21131 Location - City or Town, State
Pages	nt: If		1 M Buriai 2 U Cremation 3 U Removal from State	Lley Memorial Cardens	5-23-05 T	imonium, Maryland
Daltimor	Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility		
ā ā	impo any ii		George Cerum	Mitchell-Wiedefeld 5500 York Road Ba	l runeral i	Home, Inc. Maryland 21212
	130		23a. Part1. Enter the diselse, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate Interval Between
Ph	ysician		Immediate Cause (Final disease or condition MWW dix Lu	ng Cancer		Onset and Peath Weeks
	Medical aminer		resulting in death)  Due to (or as a consequence of):	0		
^	animici	_	Sequentially list conditions,  b. Due to or as a consequence of			
/8	nsit	Examiner	Sequentially list conditions, if any leading to annihilate and the cause. Enter Underlying Cause (Disease or injury			
V	al-tray	xar	that initiated events c.  resulting in death) Last Due to (or as a consequence of):			
9 8 8 8	siciar e buri		d			
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aw requires that the death certificate be	certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery
o deat	he att	sicis	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Day Year
F at the	by the	Phy	9 U Onknown		On Didunt	
v ≋ ≢	igne bed		Pan II. Other significant conditions contributing to death but not resulting in the Chorus Orschweline fulnulary	UNLESSE  UNDERSE		2 No 3 Probably 4 Unknown
cords, w requires t	hould	eted		OVENIE		
e aw	has b	Completed by	Moral Jishelation		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
The Tr	icate r, pag				performed 1 ☐ Yes 2 🗹	No 1 Yes 2 No
Attending Physicien:	certif	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	Othon	th (Check only one)	Issisted
2 g	r this aral d	H .	27. Manger of Death 28a, Date of Injury 28b. Time of	THE SELECT THE INDISTRIGUE	ome 5 Residence 28d. Describe how in	
Attending	Th. Afte	tion	1 Vatural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		570
I or Atte	atter dea Director Jin by the	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
To the Hospital or	within 24 hours after dearn,  To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, evestigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To th	To tt comp	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			· /WYXXXX	030433	M	My 20, 2005
	1.		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	01.00	× 140 7.301
	· pl		21 Date filed (Marth Day Veer)	CHAMUES ST	BAUTIMOR	2 21204
	Sta Registr	4 . 4	31. Date filed (Month, Day, Year)  MAY 2 4 2005  32. Registrar's Signature	- M-		
DHMH	17 Rev 1/20	· .	30. Name and address of person who completed cause of death (flem 23a) (Type M )			
			•			

ORIGINAL

Please Type or Print in Black Indelible Ink Ensure All

	ricase	Type of Frint in black indelible ink. Ensure		
	For State	State of Maryland / Department of Health and	Mental Hygiene	006
	Registrar	Certificate of Death	Reg. No. UUD	000
Physician	Decedent's Name (First, Middle, Last	°- 1	2. Date of Death  Month  Day  Year	e of Death
/Medical	MITON C.	tora	May 18, 2005 3,	32 M
Examiner	4a. Facility Name (If not institution, give	e street and number) 4b. City, Town, or Location of Dec	ath 4c. County of Death	
		ney Hospice Baltimor	e NA	
Funeral	5. Social Security Number 6. Se	7. Age (In yts. last birthday) If Under 1 Year   If Under 24 Hi	S. 8 Date of Birth 9 Birthplace (Sta	te or Foreign
Director	019-00-10001	45 Yrs. Williams Says 18813	March 31,1960 Maryla	and
and and	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location	10d Incid	City Limits
Aaryl	Manda I NI	A T 11:		es 2 □ No
the l	10e. Street and Number	Baltimore 101, Zip Code		
ath with the Marylar s 23a or 28a-f show wat be notified at	IDE N Casa	C+ APT.	10g. Citizen of What Country?	
6 uffer death with the Maryland refers 23e or 28e-f show directment be notified at	105 N. Carey	12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or No- 14. Race - American Indian	
fier dea	1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 NENo	ento Rican, etc.)	•
036 urs a	3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ☐ Yes 2 th No  If Yes, Give Year or Dates:	Specify: Rlack	1
121215-00 eled within 72 ho yglene. yglene. it, tra Medical it, tra Medical it.	15. Decedent's Edu	ucation 16a, Decedent's Usual Occupation	16b. Kind of Business/Industry	
215 P. P. P. P. P. P. P. P. P. P. P. P. P. P	(Specify only highest grad	de completed)  (Give kind of work done during most of w life. DO NOT use retired)	orking	
21.	9	O Construction La.	borer Private Como	anies
nd nd all Hy	17. Father's Name (First, Middle, Last)	18. Mother's No	ame (First, Middle, Maiden Surname)	
aryland 21215-0036 should be filed within 72 hours after and Mental Hygiene. I marked other than "natural; or lite unaffic avant, I'le Medical Exercina To Be Completed by Fur	Hercy S. to	ord Sr. Cons	stance White	
Maryland 21215-0036 d 2 should be filed within 72 hours aff th and Markal Hygiens, or T is marked other than "natural", or traumatic event, I'm Medical Extrail To Be Completed by F	19a. Informant's ame/Relationship (7)	ype, Print) Sister 19b. Mailing Address (Street and Number or F	Rural Route Number, City or Town, State, Zip Code)	
and and n 27	Ms. Brenda Y.	tord 8632 Oak Rd	. Balto, Md. 2123	.4
Ore of H r oth	20a. Method of Disposition 1 ☐ Burial 2 【■ Cremation 3 ☐ F	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State	20
Baltimore, Maryland 21215-0036 Bealtimore, Maryland 21215-0036 Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items eny injury or other traumatic event, the Medical Exprintermonce.  To Be Completed by Fune	'4 □Donation 5 □ Other (Specify)	Metro Crematory 3/2	86/2005 Balto Ma	<i>l</i> .
Balt Barti Departi Import	21. Signature of Funeral Service/Licens		T	-
m #9 = # 9	pseph	1. Buss 2222 W. North Al	le Baito Md. 21216	
•	23a. Part 1. Enter the dispase, or composhodly or heart failure. List only of	lications that caused the death. Do not enter the mode of dying, such as cardione cause on each line.	ac or respiratory arrest, Approxim	nate Retween
Physician			Onset ar	nd Death
/Medical	resulting in death)	Due to (or as a consequence of):	2 30	
Examiner	Sequentially list conditions	HIV (Human I mount defecient Ve my) AIDs	unknow	) m.
32 0, c executed inal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to or as a consequence of):		
60, c be executed cician and burial-transiti	that initiated events resulting in death) Last	C. INTRAVENINDRUG ABURE		
7 3 3 1760,	rosaking in doalin) Edist	Due to (or as a consequence of):		
1 5 8 5 0		d		
P.O. Box 68 nat the death certifical d by the attending philetached for use as the Physician/Medi	IF FEMALE:			
BO)	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy	23d. Date of delivery  Month Day	Year
O. O. ithe de shed the de the	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	Month Day	1941
IS, P.O. Box 68 is had the death certificate by the attending phose detached for use as it by Physician/Medi	Part II Other significant conditions co	intributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of	4 do o the
ds, disserting signer of the dispersion of the d		to previous gaitnestomy Hegatitis B infact		
Cord M requir Should	The state of the s			
al Record The law requir cate has been si page 2 should	Insulin degendent di	abeter, history at bilateral lower extremity	24a. Was an autopsy autopsy 24b. Were autopsy finding prior to completion o	s available cause of
Th Th		•	performed? death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No	
m : 0 .	deer venous thumboris			
Vita Vita ician: ector,	25. Was case referred to medical examiner?	Hospital:	eath (Check only one)	2. 4.2
of Vital Physician: 1 this certifica	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐Other (Specify)	fic-t pice
on of Vita on of Vita ding Phyaician: After this certific tuneral director,	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1  Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing  28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?	Home ED Besideres & Thibas (Carata Tayes	
islon of Vita death.  Attending Physician: death.  stor: After this certific, the funeral director.	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1  Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing  28a. Date of Injury (Month, Day Year)	Home 5 Residence 6 Fother (Specify)	PICE
Division of Vita after death.  Division of Vita after death.  Director: After this certification. To Be extribited to the formal director.	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1  Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing  28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?	Home 5 ☐ Residence 6 ☐Other (Specify)	PICE
Division of Vita  Division of Vita  Ours after death.  Anal Director: After this certification by the funeral director.  Illed in by the funeral director.	25. Was case referred to medical examiner?  1	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing    28a. Date of Injury (Month, Day Year)   28b. Time of Injury   Work?   1   Yes 2   No    28e. Place of Injury - At home, farm, street, factory, office	Home 5 Residence 6 Hother (Specify)  28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route No. City or Town, State)	PICE
Hilth Considerate Division of Vita  Division of Vita 24 hours after death. 24 hours after death. 8 Funeral Director: After this certific etely filled in by the funeral director.  dical Certification; To Be (	25. Wis case referred to medical examiner?  1	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing    28a. Date of Injury (Month, Day Year)   28b. Time of Injury   Work?   1   Yes 2   No    28e. Place of Injury - At home, farm, street, factory, office	Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route No. City or Town, State)	Imber,
Division of Vita  Division of Vita  To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director.  Medical Certification; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manger of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Physic (Check only)  2 Medical Examiner	Hospital: 1	Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route No. City or Town, State)	p) CE umber,
Division of Vite rate or Attending Physician rs after death.  al Director: After this certification by the funeral director Certification: To Be	25. Wis case referred to medical examiner?  1 Yes 2 No  27. Manger of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  25. We case referred to medical examined  5 Pending investigation 6 Could not be determined	Hospital: 1	Home 5 Residence 6 Mother (Specify)  28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route No. City or Town, State)  18e. and due to the cause(s) and manner as stated.  18e. and due to the cause and place, and due to the cause	p) CE umber,
Hi HDM C   Division of Vita  To the Hospital or Attending Physician: within 24 hours after death. To the Funarel Director: After this certific completely filled in by the funeral director.  Medical Certification: To Be	25. Was case referred to medical examiner?  1	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing    28a. Date of Injury (Month, Day Year)   28b. Time of Injury   Work?   1   Yes 2   No    28e. Place of Injury - At home, farm, street, factory, office    28c. Injury at Work?   1   Yes 2   No    28c. Place of Injury - At home, farm, street, factory, office    28c. Injury at Work?   1   Yes 2   No    28c. Injury at work?   1   Yes 2   Yes 2   Yes 2    28c. Injury at work?   1   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2    28c. Injury at work?   1   Yes 2	Home 5 Residence 6 Mother (Specify)  28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route No. City or Town, State)  29d. and due to the cause(s) and manner as stated.  29d. Date signed (Month, Day, Year,	p) CE umber,
Division of Vita  Division of Vita  To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director.  Medical Certification; To Be	25. Was case referred to medical examiner?  1	Hospital: 1	Home 5 Residence 6 Mother (Specify)  28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route No. City or Town, State)  29d. and due to the cause(s) and manner as stated.  29d. Date signed (Month, Day, Year,	p) CE umber,
Division of Vita  Division of Vita  To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director.  Medical Certification; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manger of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of errin who co	Hospital: 1  Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  1 Yes 2 No  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28c. Injury at Work?  1 Yes 2 No  28c. Injury at Work?  1 Yes 2 No  28c. Injury at Work?  1 Yes 2 No  28c. Injury at Work?  29c. License and place and place inter: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place inter: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place inter: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place inter: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place inter: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place inter: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place inter: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place inter: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place inter: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place inter: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place inter: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place inter: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place inter: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place inter: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place inter: On the basis of examination and/or investig	Home 5 Residence 6 Mother (Specify)  28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route No. City or Town, State)  29d. and due to the cause(s) and manner as stated.  29d. Date signed (Month, Day, Year,	p) CE umber,

John A. Farley, Jr. 05-03492 RJ

			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of rtificate of		ınd Mental H	ygiene Reg. No.	005	17387
		П	1. Decedent's Name (First, Middle, Last)					2. Date of I	Death		3. Time of Death
ı	Physici /Medi		JOHN	ALOYSIUS	FARLEY, JE	₹.		May 2	20, <b>2</b> 00	5 Year	10:00 a₩
	Examir		4a. Facility Name (If not institution, give		, , ,	4b. City, Town,		f Death		unty of Death	
			#3 Bellemore Road			Ro1and	Park,	Baltimore		N/A	
	Funeral		Social Security Number     6. Security Number	7. Age	(In yrs. last birthday)	If Under 1 Year Months Days			Birth Day, Year)		place (State or Foreign
	Director			M 2□F	84 Yrs.	WOILIS Days	Hours		. 1921		ryland
	and w		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or Lo	ecation			,		
	faryla sho	ក	NT.	^^							10d. Inside City Limits 1   Yes 2   No
	28a-	Director	Maryland N/	Α	Baltim	ore 10f. Zip Code			40 000		41
	with Ba or		3 Bellemore Road				21210		Tog. Citizen	of What Coul	nury ?
	leath	era		12. Was Decedent B	ver in U.S. 13.1		21210	rin? (Specify Yes or N	10- 14	USA Race - Americ	can Indian
(0	r Itar r Itar niner	Funeral	1 ☐ Never Married 2 🏋 Married	Armed Forces? 112 Yes 2 □ N		f Yes, specify Cul	ban, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	14.	Black, White,	
<u>8</u>	al', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	WWII	1□Yes 21 No	Specify:		Spe	ecify: W	√hite
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Itams 23a or 28a-f show Ita Mudical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Deced	dent's Usual Occu	pation	-4 -41-	16b. Kind o	of Business/In	dustry
2	thin 19.	nple	Elementary/Secondary (0-12)	College (1-4or 5	life	kind of work done OO NOT use retire	ed)	or working			
	ed windspending the second of	Con		5+	Atto	rney at	Law		I	ega1	
Maryland	tal H d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother	's Name (First, Midd	le, Maiden Sun	name)	
$\frac{1}{2}$	ould Men Parka	<sup>2</sup>	John Aloysius Fa					Pauline		Koh1e	
ā	2 sh and Is m		19a. Informant's Name/Relationship (Ty)	•				r or Rural Route Num			
	l and lealth em 27 ther t		Mrs. Patricia O'C	onor Fari	, , ,	11emore	Road,	Baltimore			
Ö	gas it of the		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ R	emoval from State		natory or other pla	, I	Date		on - City or To	
altimore,	t. Pa rtmer rtant:		`4 ☐Donation 5 ☐ Other (Specify)		St. Mary	s Ch Ce	metery	5/25/2005	Home1a	and, Bal	lto,MD
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itams 23a or 28a-f show any injury or other traumatic event, It a Medical Examiner must be notified at ance.		21. Signature of Funeral Service License	2000		Name and Addr		feld Funer	al Home	Tnc	
			Martin D. Laws  23a. Part 1. Enter the disease, or compli	son	the death. Do not not	6500 Yor	k Road	Baltimor	e. Mar	vland	21212
			shock, or heart failure. List only on Immediate Cause (Final	e cause on each lin	θ.						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	hyperten	sive other	osclero	tic Cas	diovasce	las dis	Res 4	
	Examiner			to (or as a	consequence of):						
4		er	Sequentially list conditions, if any, leading to immediate		consequence of):					-	
V	utad d ansit	min	cause. Enter Underlying Cause (Disease or injury that initiated events								
Ć.	execunation and ital-tr.	Examin	resulting in death) Last	Due to (or as a	consequence of):						
8760,	cate be executad physician and the burial-transit	dlcal									
9		Med	IF FF. W. F.		-						
Вох	death certifi e attanding I id for use as	Physiclan/Me	250. Was decedent pregnant	3c. If yes, outcome of 1 Live birth 2	of pregnancy	Ectopic pregnanc	~		23d.	Date of delive	ery
	D 0 D	sicl	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at t 9□ Unknown		Other (specify)	, y			Month	Day Year
о. О	at the ded by the setached	Phy	9 Unknown						- 4		
Ś	requires that the een signed by th hould be detache	by	Part II. Other significant conditions con	tributing to death bu	t not resulting in the ur	iderlying cause gr	ven in Part I.				ne cause of death?
ecords,	w requir been si should I	ted						_   1	Yes 2 □ No	3 Prob	ably 4 Unknown
ဝ	The law ite has b age 2 sl	Completed						24a. Wa:	opsv	prior to con	psy findings available inpletion of cause of
<u> </u>		Co						1 XYes	ormed? 2 □ No	death? 1 Yes	2□ No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		04		of Death (Check only	опе)		
ō	Phys	<u>L</u>	1x Yes 2 No 27. Manner of Death	1 Inpatier		JU DON		sing Home 5 Res			Scene
0	fter fter	tlon	1 XNatural 5 ☐ Pending	(Month, Day	Year) 28b. Time of Injury	28c. Inju Wo M 1	ryat irk? ]Yes 2∐Ne		how injury occ	curred	
Division	or Attending after death. Director: After in by the fune	ertification:	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Injur	y - At home, farm, stre		162 5 14		Street and Nu	mhor or Pura	l Route Number,
2	el or Attendia safter death. Il Director: A d in by the fu	erti	4 ☐ Homicide determined	building, etc.	(Specify)	et, lactory, office		City or To	wn, State)	mber or murai	Houle Number,
	spite	alc	29a. Certifier 1 ☐ Certifying Phys	ician: To the best of	my knowledge, death	occurred at the ti	me date and	place, and due to the	cause(s) and	manner as st	ated
	e Ho 124 h e Fu	edical	(Check only one) 2 Medical Examin	er: On the basis of and manner stat	examination and/or inv	estigation, in my	opinion, death	occurred at the time	date and plac	e, and due to	the cause(s)
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	Me	29b. Signature and title of certifier	·	$\bigcirc$	29c. Licens	se number		29d. Date sig	ned (Month, L	Dey, Year)
			Habre an	on ic	-taller.	OCM	E		May 21	, 2005	
	10		30 Name and address of person who con	npleted cause of de	ath (Item 23a) (Type, F	Print)					
	20		PATRICIA AMNI	CA-KOIL	AK MD	111 Penr	Stree	t Baltimo	ore. Ma	rvland	21.201
	Sta	-	31. Date filed (Month PAY 9 4 20	05 32. Distrai	's Signature				3		
	Registra	ar		A Wallace	. / /	BARS B					

Ngthan Joseph Frank

			1 - For State Registrar	State of Maryland / Dep. Ce	artment of Health and rtificate of Death		iene 05	17388
	Physic	ian	Decedent's Name (First, Middle, Last)		2. Date of Deal Month	Day Year	3. Time of Death	
	/Medi	cal	NATHAN  4a. Facility Name (If not institution, give s	FRANK  4b. City, Town, or Location of Dea	May	21 2003		
	Examir	ner	ST. MARYS HOSPITAL		LEONARDTOWN	ıın	ST. MAR	
	Funeral	Т		7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs		9. Birti	nplace (State or Foreign untry)
	Director		217-03-0077	M 2 F 91 Yrs.	Months Days Hours Min	07/03/	1913	N.Y.
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Mary a-f eh	ţō	MD ST. MARY	'S LEONARDT	OWN			1 □Yes 2 No
	th the	Director	10e. Street and Number		10f. Zip Code	1	0g. Citizen of What Co	untry?
	ath wi	rai	22680 CEDAR LANE		20650		U.S.A	١.
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Menial Hygiene. If Itiem 27 ia marked other than "natural", or Itams 23a or 28a-f ehow or other traumatic event, the Medical Examinat must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	1 M Yes 2 No WW II	Was Decedent of Hispanic Origin? (stif Yes, specify Cuban, Mexican, Puel 1 ☐ Yes 2 No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White Specify:	
5-0	72 ho	etec	15. Decedent's Educ (Specify only highest grade	ation 16a. Dece	dent's Usual Occupation	orkina C	16b. Kind of Business/I	ndustry
121	filed within Hygiene. Ither than "	Completed	Elementary/Secondary (0-12)	College (1-40r 5+)	kind of work done during most of wo DO NOT use retired)	P	ATUXENT NA AIR STAT	
	filed with Hygiene. other than	ပိ	17. Father's Name (First, Middle, Last)	2 META		me (First, Middle, A		
Maryland	should be Ind Mental ind Mental is marked o	To Be	HARRY	FRAI			,	BOSH
lary	and N la ma	1	19a. Informant's Name/Relationship (Typ		ng Address (Street and Number or R			
	and lealth m 27 her tr		MARVIN FRANK / BR		MINNETONKA ROAD			
Baltimore,	Pages 1 nent of F int: If ite		20a. Method of Disposition  1 D Burial 2 Cremation 3 Re		matory or other place)	1	20c. Location - City or 1	
뜵			* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	FORBAND (	2. Name and Address of Facility S		ROSEDALE, M	
Ba	permit. Departr Imports any inju		Edward Ci	Keussa 89	900 REISTERSTOWN	ROAD - PI	KESVILLE,	
	Priysician /Medical		shock, or heart failure. List only one shock, or heart failure. List only one limmediate Cause (Final disease or condition resulting in death)	PREUMONIA	ter the mode of dying, such as cardia	c or respiratory arre	est,	Approximate Interval Batween Onset and Death
	Examiner		f	Due to (or as a consequence of):	heart Eauce	05		wence
		Jer	Sequentially list conditions, if any leading to immediate cause. Enter I Indertying	Due to for as a consequence of):	hepit Foly	16	-	jugas
	sician and burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		MITERY ALSE	115C	YEARS	
60,	iticate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a conseque / of):	(			/
68760,	phy:	edical	d.					
O. Box (	ath cert	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of deliv	very Day Year
σ <u>.</u>	res that the de signed by the a be detached t	by Ph	Part II. Other significant conditions cont	ributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
rds	w requires been sig should b		typenters	100		1 🗆 Ye	s 2 No 3 □ Pro	bably 4 Dunknown
of Vital Records,	e law requ has been je 2 shoul	Completed	Fortic St	-en0515		24a. Was an	24b. Were aut	opsy findings available ompletion of cause of
<u> </u>		Com				perform	led; death?	2 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:	04	ath (Check only one		- m
o	Phys r this ral dii	7. To	1 Yes 2 No	1 ☐ Inpatient 2 ☐ Coutpatien 28a. Date of Injury 28b. Time of		forme 5 Resider	nce 6 Other (Speci	fy)
lon	nding F ith: :: Atter e tuner	ation	1 Natural 5 Pending investigation	(Month, Day Year) Injury	f 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	200. 100501100 110	w injury occurred	
Division	To the Hospital or Attending within 24 hours atter death. To the Funeral Director: Attercompletely tilled in by the tune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, stribuilding, etc. (Specify)	eet, factory, office	28f. Location (Str. City or Town,	eet and Number or Run State)	al Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely tilled in	edical (	29a. Certifier (Check only one) 1 Actifying Physical Examination (Check only one)	cien: To the best of my knowledge, deather: On the basis of examination and/or invand manner stated.	n occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the car arred at the time, da	use(s) and manner as s te and place, and due t	stated. o the cause(s)
	To the within to the total comp	Σ	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Month,	Day, Year)
•	1		11/1/1/19	-De	1)57074	1	lay 21.	2005
	4			npleted cause of death (Item 23a) (Type,		4 14		N.D. O.
	- Cho	10	31. Date filed (Month, Day, Year)	ST Marys 32. Registrar's Signature	Hospital P.O.B	ox 527	reouristen	n MD 20650
	∗ Sta Registr	200	MAY 2 4 2005	Herry It Appea	The state of the s			

DHMH 17 Rev 1/2001

10

State Registrar SHER A HASHMI, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

31. Date filed (Month, Day, Year) MAY 2 4 2005

			1- For Amend Item 10b per fh G843 5-24-05 tas Registrar
			1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Year  2. Date of Death
	Physicia /Medic		DOLORES B. GIENTRY May 21, 2005 6 5 PM
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
	Funeral Director		5. Social Security Number  6. Sex 1 Age (In yrs. last birthday)  7. Age (In yrs. last birthday)  1 M 200 F  1 M 200 F  1 M 200 F  1 Months Days Hours Min.  1 M 200 F  1 Months Days Hours Min.  1 M 200 F  1 M 200 F  1 M 200 F  1 M 200 F  1 M 200 F  1 M 200 F  1 M 200 F  1 M 200 F  1 M 200 F  1 M 200 F  1 M 200 F  1 M 200 F  1 M 200 F  1 M 200 F  2 M 200 F  3 M 200 F  3 M 200 F  4 M 200 F  2 M 200 F  3 M 200 F  4 M 200 F  2 M 200 F  3 M 200 F  4 M 2
			Usual Residence of Decedent
	rylan		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	8a-fs	Director	190 Daltimine Daltimine
	with th	Dire	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	eath is 23	Funeral	4/16 St. Thomas Ave. 2/206 C.S.A.  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian,
(0	r iten	Fun	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Never Married 2 Married 1 Yes 2 No
21215-0036	72 hours after death with the Maryland natural; or items 23a or 28a-f show Jeal Examine must be motified a	d by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates: 1 □ Yes 2 □ No Specify: Specify: Specify: Black
5-0	72 h "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry
121	within iene.	dmo	Elementary/Secondary (0-12) College (1-4 or 5+)  Board of Education  Baltimore City
	filed Hygi other	0	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
Maryland	2 should be and Mental Is marked of sumatic eve	To B	CORNILUS CANNON BERNICE BANKS
lary	should and Men is marke		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
_	and ealth n 27 ner ti		Charleve Grentry-daughter 4116 ST. Thomas AVE. Balto, MD 21204
Baltimore,	Pages 1 nent of Hi nut: If iter iry or oth		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State
ţ	permit. Pag Department Importent: I any injury o		4 Donation 5 Other (Specify) Our 1504 Forest Ceyckry 19ay 31, 2015 Baltiyore
Bal	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Bradley-Ash ton Funeral Home, P.A.  21.34 WILLOW 3Dring Rd. 21222
			23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate
	Physician		shock, or heart failure. List only one cause on each line.  Interval Between Onset and Death  Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  Due to (or as a consequence of):
	Examiner		Sequentially list conditions, b. "Atheroscheroscy
	pe is	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury
	xecut and al-tran	хап	that initiated events resulting in death) Last C. Due to (or as a consequence of):
8760,	death certificate be executed e attending physician and id for use as the burial-transit		d
9	tificate ig phys as the	ledi	
Вох	leath certifica attending ph I for use as th	an/N	IF FEMALE:   23c. ff yes, outcome of pregnancy   23d. Date of delivery   1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Day   Year
	that the death ed by the atte detached for	Physician/Medical	in the past 12 months?  1
P.0	The law requires that the ste has been signed by th page 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
of Vital Records,	signe d be	d by	Coron any centery discuse 1 TYes 2 No 3 probably 4 Unknown
20	w requir been si should	Completed	24a. Was an 24b. Were autopsy findings available
Re	The lay	dwo	autopsy prior to completion of cause of death?  1
ital		0	25. Was case referred to medical 26. Place of Death (Check only one)
<u> </u>	dis S	To B	examiner?  1   Yes 2   No
o u	ding Ph th. After th funeral		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. fnjury at Work?  28d. Describe how injury occurred Work?
sio	tendi Jeath. tor: A	cati	2 Accident investigation   M   1 Yes 2 No   3 Suicide 6 Could mixed = 28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number,
Division	To the Hospital or Attending P within 24 hours after death. To the Funerel Director: After completely filled in by the funera	Certification;	3 Suicide determined determined determined determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	spita nours nerei		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	n 24 h	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	with To t	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	./		1 Gaty MD 132118 5-23-05
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	Sta	te	31. Date filed (Month, Day, Year)  32. Registrats Signature
	Registr		MAY 2 4 2005 Reserve 13. Parisi

OPM 05-03499 Giorgina Guerrini

0			For State Registrar	State of	f Marylan	•	artment of latificate of			_	giene Reg. No.	005	173	91	
			1. Decedent's Name (First, Midd						2. Oate of De		Vana	3. Time of	Death		
	Physici		(	Giorgina G	errini					Month May	20		12:01	ΙΔ <sup>M</sup>	
	/Medic Examir		4a. Facility Name (If not institution	on, give street and nur	nber)		4b. City, Town,	or Location	of Death	· May		County of Death	12.00		
1			311 Beech Grov	e Court			Millers	sville	,		A.	nne Arun	de1		
	Funeral		Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under		8. Date of Bir (Month, Da	th		lace (State o	or Foreign	
	Director		None	1 ☐ M 24 🖸 F	88	Yrs.	Michillis Days	Hours	IVIII.	AUG 10			alv		
	P .		Usual Residence of Decedent		1										
	how	_	10a. State 10b. Count		10c. Cit	ty. Town or Lo	cation					1	0d. Inside Ci	*	
	Pe-1-	cto	Italy N/	Α			Viada	ana					1 ☐ Yes	Z XIAO	
	h with th	al Dire	10e. Street and Number Viale Orefic	e #6			10f. Zip Code 46	6019			10g. Citiz	zen of What Cour Italy	itry?		
	ms 2	Jera	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13. \	Was Decedent of f Yes, specify Cut	Hispanic Or	rigin? (Spe	city Yes or No	- 1	14. Race - Americ			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel" or Items 23e or 28e-f e-how any injury or other treumatic event. Ite Medical Enair actimatics rectified at anote.	by Funeral Director	1 ☐ Never Married 2 ☐ Ma 3 🛣 Widowed 4 ☐ Divorce	Man Ch	2 ₽ No 'e	i	TYes, specify Cur 1 ☐ Yes 2 Ho			rican, etc.)		Black, White, Specify: Wh	ite		
Ö	2 hou	Completed		nt's Education			lent's Usual Occu				16b. Kin	nd of Business/Inc	dustry		
212	nin 7 nin ni nin ni	ple	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1	-4or 5+)	life. I	kind of work done DO NOT use retire	auring mos ad)	st of workir	-					
212	d with	E O	Elonomary Co 12/	College (	1	Ac	countant	-			Frui	t Import	./Expoi	st	
	othe	Bec	17. Father's Name (First, Middle							(First, Middle,		Sumame)			
<u>la</u> r	Ald but Alenta	To	Vittorio G	uerrini					Anna	Drzemi	zeka				
Maryland	shod Nama	•	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailin	g Address (Stree	t and Numb	er or Rura	Route Numbe	er, City or	Town, State, Zip	Code)		
	alth alth 27 I		Anna T. Smith	/daughter		311	Beech (	Grove	Court	Mill Mill	ersv	ille, M	21108	3	
ore	of He of He		20a. Method of Disposition	2 Dam such from	20b. F	Place of Dispo	sition (Name of natory or other pla	1ce)_	D	ate		cation - City or To			
E	Page nent of		1 ☐ Burial 2 ♣ Cremation  4 ☐ Donation 5 ☐ Other (		Me Me	etro Cr	ematory or other players,	Inc.	5/23	3/05	В	altimore	, MD		
Baltimore,	permit. Departri Importe any inju		21. Signature of Funeral Service Thomas Gre			22	Name and Addr remation 99 Frede	ess of Facult 1 SOC1	ety o	of Mary	land	, Inc.	28		
			23a. Part1. Enter the disease.	or complications that c	aused the deat							, 1111 212	Approximate Interval Bet	е	
	Dhusisian		shock, or heart failure. Lis Immediate Cause (Final			: _1_	C1:						Onset and I		
	Physician /Medical		disease or condition resulting in death)		or as a conseq		Complica	LIOIIS							
н	Examiner			b		,									
		e	Sequentially list conditions, if any, leading to immediate	uence of):											
/	uted J ansit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												
Ć.	icate be executed physicien and the burial-transit	Еха	resulting in death) Last Due to (or as a consequence of):												
8760,	e be /sicie e bur	cal	ā												
99	ificat g phy as th	edl													
Вох	The law requires that the death certificate has been signed by the attending sage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna		Ectopic pregnanc	24			2	3d. Date of delive			
	death e atte	ICIB	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregn	ant at time of d		Other (specify)					Month Day Year			
P.0	t the by th tache	hys	9 🗆 Unknown	9□ Unkno	)WN								<u> </u>		
	w requires that s been signed b should be deta	by P	Part II. Dther significant condit	ions contributing to de	eath but not res	ulting in the u	nderlying cause gr	ven in Part I	l.	23e. Did t	obacco us	se contribute to th	e cause of d	eath?	
rd	an sig	ed								1 0	∕es 2□	No 3∏Prob	ably 4 □L	Jnknown	
Records,	s bee	Completed								24a. Was		24b. Were auto	osy findings a	available	
R	sician: The law certificate has b irector, page 2 s	E								perfo	rmed? 2 <b>X</b> No	death?	2□ No	1050 01	
Vital		0	25. Was case referred to medic	al			-	26 Place	e of Death	(Check only o		1 2 103	20110		
>	Physician: this certific ral director,	To B	examiner? 1 <b>T</b> Yes 2 □ No	Hospital:	npatient 2	ER/Outpatien	t 3 DOA Ot	4				Nother (Specify	SCEN	Œ	
of	ding Phy I. After thii funeral c		27. Manner of Death	28a. Date	of Injury	28b. Time of				8d. Describe I			. 10	11	
lon	ith. TAfte	atlo	1 □ Natural 5 □ Pend 2 📉 Accident inves	igation 3/2	h, Pay Year)	unioniw	M 1	Yes 2	No			SKE	ject te	//	
Division	Attending it death. ector: After by the fune	Certification:	3 ☐ Suicide 6 ☐ Could	mined 286. Place	of Injury - At ho	ome, farm, str	et, factory, office		2	8f. Location (5	Street and	Number or Rura			
Di	afte afte	ert	4  Homicide	Buildii	ng, etc. (Specif	siene			0	city or Tov	lilkrsv	311 Jacob	h Grove	•	
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certify	ng Physicien: To the	best of my kno	wledge, death	occurred at the t	ime, date ar	nd place, a	nd due to the	cause(s) a	and manner as st	ated.		
	ne Hc ne Fu ne Fu	Medical	(Check only 2 ★ Medica one)	l Exeminer: On the ba and mann	asis of examina ner stated.	ition and/or inv	estigation, in my	opinion, dea	ath occurre	at the time,	gate and	piace, and due to	tne cause(s	)	
	To the To the To the Comp	ž	29b. Signature and title of certifi	er .			29c. Licen OCI	se number				signed (Month,			
)			1 tample 4	Josepha 11	MI		001	. III			May	24, 200	5		
	ix		30. Name and address of person	who completed caus	e of death (Iten	n 23a) (Type.	Print)					36 -	1 015	01	
	* /		Pamela E	who completed caus	MD	_	III Per	nn Str	reet	Baltin	ore,	Marylan	id 212(	JΙ	
	Sta	te	31. Date filed (Month, Day, Year		egistrar's Signa										
	Registr	- T. I	MAY 242	2005	yas St.	Signal	The state of the s								

			1 - For State Registrar	State of Maryland		rtment of H			giene ) (	)5	17392
	Physici		1. Decedent's Name (First, Middle, Last)  6 abri elle	Hamilton - V	vut c	4		2. Date of Dea	Day	Year_	3. Time of Death
	/Medio Examin		011.0.5.1	eryland sys	tein	4b. City, Town, or るん	timer	۷	4c. County	Α	
ı	Funeral Director		5. Social Security Nurthber 6. Sex  N/A  Usual Residence of Decedent	M 2XXF	st birthday) _ Yrs.	If Under 1 Year Months Days	Hours Min. 2	8. Date of Birt (Month, Da MARCH 1	y, Year)		place (State or Foreign htry) YLAND
the Maryland	h the Maryland or 28a-f show	Director	10a. State 10b. County  MARYLAND HARFOR  10e. Street and Number		Town or Loc	LSTON			10g. Citizen of W		10d. Inside City Limits 1 ☐ Yes 2XXIvo
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. Importent: If them 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumette event, the Medical Examinar must be notified at once.	by Funeral D	2009 RUTLEDGE ROA  11. Marital Status  **DXNever Married 2   Married 3   Widowed 4   Divorced	2. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2\text{2}\text{No} If Yes, Give Year or Dates:	1	210 das Decedent of His Yes, specify Cubar		pecify Yes or No- o Rican, etc.)			
N-61212	od within 72 hou giene. er than "nature in the Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) N/A		(Give k life. D	ent's Usual Occupa ind of work done di O NOT use retired) /A	uring most of wor		16b. Kind of Bu		dustry
	should be file nd Mental Hy i marked oth umetic event	To Be (	17. Father's Name (First, Middle, Last) DAVID KOBLA WUTO	Н				ne (First, Middle, Y LYNN H		9)	
Mar	and 2 sho Balth and n 27 is m		19a. Informant's Name/Relationship (Ty)  David Wutoh/Sherry	i i		Address (Street a					·
altillore,	Pages 1 a nent of He int: If item iry or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State 20b. Plac	ce of Dispos netery, crem	ition <i>(Name of</i> atory or other place CEMETERY	)	Date 19-05	20c. Location -	City or To	own, State
סמוב	permit. Departm Importe any inju		21. Signature of Funeral Service License		22. WM	Name and Address C BROWN 1 S PHILE	of Facility COMM FU	NERAL HO	ME-HARF	ORD,	P.A.
	Pnysician /Medical Examiner	0 1	23a Part 1. Enter the disease, or complished, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	Due to (or as a consequent	Pr	the mode of dying	(	or respiratory ar	rest,		Approximate Interval Between Onset and Death
,0070	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause the first order of the control of the cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C								
O. DOX O	w requires that the death certific been signed by the attending p should be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (specify)						23d. Date of delivery Month Day Year		
Crus, r.	quires that n signed by uld be deta	by							tobacco use contribute to the cause of death?		
מספע וג	: The law rec cate has bee , page 2 shou	Completed						24a. Was a autop perfor 1 Tyes	sy pr med? de	rior to cor eath?	psy findings available impletion of cause of
UNISION VITAI NECOLUS, T.C. BOX 00/	To the Hospitel or Attending Physicien: The law within 24 burus after death. To the Funeret Director: Atten this certificate has completely filled in by the funeral director, page 2	tion; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation		26. Place of Death (Check only one)  2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  28b. Time of Injury Work?  M 1 Yes 2 No						")
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (S City or Tow	itreet and Numbe n, State)	r or Rura	l Route Number,
	the Hospit in 24 hour the Funer ipletely filk	Medical (	29a. Certifier (Check only one) Certifying Phys	ician: To the best of my knowle er: On the basis of examination and manner stated.	edge, death n and/or inve	occurred at the time estigation, in my opi	e, date and place nion, death occu	, and due to the d rred at the time, d	cause(s) and mar date and place, a	ner as st	ated. the cause(s)
	To With Com	2	29b. Signature and fitte of certifier	and manner stated.  10  11  11  12  12  13  14  15  16  17  17  18  18  18  18  18  18  18  18		D G	2150		29d. Date signed	(Month, i	Jay, Year)
			30. Name and address of person who co	npleted cause of death (Item 2	3a) (Type, P	rint)	+, Bal	timore	MD	212	र <b>ः (</b>
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 2 4 2005	negistral s signatur	Some	K)					

			Ple	ase Type or Pri					_		egible.		
			1 - For State Registrar	State of M	aryland / L		icate of l		vientai ny	Reg. No.	05	17393	
	Physici	-	1. Decedent's Name (First, Mid		_				2. Date of D	eath Day	Year	3. Time of Death	
	/Medic		Margaret		olmes				May	19	2005	6:56 A <sup>M</sup>	
	Examin	ner	4a. Facility Name (If not instituti			4b	•	Location of Death	1		ounty of Death		
_			North Arunde	<del></del>	e (In yrs. last bir	thday) If	Under 1 Year	n Burnie	8. Date of Bi	rth	nne Aru		
	Funeral Director		403-26-7670	1 □ M 2 <b>X</b> ] F			onths Days	Hours Min.	(Month, D	4 1922	Cou	place (State or Foreign ntry) IN	
	ס		Usual Residence of Decedent						0417 2	7 1322			
	show	-	10a. State 10b. Coun		10c. City, Town	n or Locatio						10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	8a-f	ecto		e Arundel			Pasa	dena		40- Cities			
	a or 2	Funeral Directo	10e. Street and Number 4485 Mountain	Doad		,	Of. Zip Code	21122		Tog. Citizer	of What Cou USA	ntry ?	
	eath	erai	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was	Decedent of Hi	ispanic Origin? (S n, Mexican, Puert	pecify Yes or N	0- 14.	Race - Ameri	can Indian,	
0	or Iter	표	1 ☐ Never Married 2 🔀 Ma	Armed Forces? arried 1 ☐ Yes 2 🔯	)	i			o Rican, etc.)	1	Black, White,		
3	ral', o	1 by	3 Widowed 4 Divorce	ed If Yes, Give Year or Dates:	If Yes, Give Year or Dates:		Yes 2∭ No	Specify:	_	Sp	ecify: Whi	te	
2	72 h	etec		ent's Education hest grade completed)	16a.	Decedent' (Give kind	s Usual Occupa of work done	ation during most of wor )	king	16b. Kind	of Business/In	dustry	
V	filed within 72 hours after death with the Maryland Hybjone. ther than "natural", or Iteme 23a or 28a-f show ant, it a Madical Examiner must be notified at	Completed	Elementary/Secondary (0-12	College (1-4or	5+)		memaker			Ш	nusobol	d	
מא	Hygie Hygie ther ent, the		17. Father's Name (First, Middle	e, Last)		110	memaker	18. Mother's Nar	ne (First, Middle		Household  den Sumame)		
land	lid be lental rked c	To Be	John J.	Riplinger				Estelle	e M.	Cle	erkin		
a Z	2 should and Men is marks sumatic		19a. Informant's Name/Relation	nship (Type, Print)	19b	. Mailing A	ddress (Street a	and Number or Ru	ıral Route Numb	er, City or To	own, State, Zip	Code)	
≥	and 2 saith n 27 i		Hugh K. Holmes	s (spouse				n Road, F					
ore	Jes 1 of He if Iter		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	n 3 Removal from State	20b. Place of cemeter	f Disposition ry, cremato	n (Name of ry or other plac	e) May	Date 23	20c. Locat	ion - City or To	own, State	
апптог	tment:		`4 □Donation 5 □ Other		Glen I		_Cemete	ry   20	005			, Maryland	
g D	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygione. Department of Health and Mental Hygione. In the Marylan I standard other than "natural; or teme 23a or 28a-f show any injury or other traumatic event, it is Marical Examinational bancelling at once.		21. Signature of Funeral Servi	.a Licencee			me and Addres					Home, P.A.	
	_		23a. Part1. Enter the disease, shock, or heart failure. Li	or complications hat cause	d the death. Do r	not enter th	e mode of dyin	tain Road g, such as cardiad	or respiratory a	arrest,	אט בווב	Approximate	
	Dhysisian		Immediate Cause (Final		no. ARDIAL		FARC	Doal				Interval 8etween Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a	a consequence		7717100	11014				MINUTES	
	Examiner		Suggestially list conditions	b									
۰	sit ad	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):							
	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Examin	that initiated events c. resulting in death) Last Due to (or as a consequence of):								-		
	s be e sician	=	d										
200	ificate g phy as the	edic											
X O O	th cert endin r use	M/us	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy							23d	23d. Date of delivery		
	that the death certificate be ed by the attending physicial detached for use as the bu	Physician/Medica	in the past 12 months?		4 Pregnant at time of death 5 ☐ Other (specify)						Month Day Year		
	hat the d by t letach		9 Unknown	itions contributing to death b	out not resulting in	the under	lving cause give	en in Part I	23e. Did	tobacco use	contribute to t	he cause of death?	
	signe d be c	d by	HYPERTENSIA	significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacc							2 No 3 Probably 4 □Unknown		
ecords	law requires as been sign 2 should be	Completed	HYPERLIA	DEALO				/	24a. Was	san 2	24b. Were autopsy findings available		
Ĕ	a se c	т	(1710) - 11	10219 11)					auto perf	psy ormed?	prior to co death?	mpletion of cause of	
	an: T tificate tor, pa	C	25. Was case referred to media	cal				26. Place of Dea	1 ☐ Yes	2X No	1 🗆 Yəs	2   No	
<u> </u>	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2☐ÎNo	Hospital:	ent 2 ER/Ou	itpatient 3	DOA Othe	ar.	ome 5 Res		Other (Specif	(y)	
0 -	ding Phys After this funeral di		27. Manner of Death	28a. Date of Inju	iry 28b. 7	Time of njury	28c. Injury Work	at c?	28d. Describe	how injury o	ccurred		
Vision	tendii eath, tor: A the fu	catio		stigation				Yes 2 □No	00/ 11	/04			
<u> </u>	or At after d Direct in by	ertification:		28e. Place of Injury	ury - At home, fa c. <i>(Specify)</i>	rm, street,	factory, office		City or To	wn, State)	um <i>ber</i> or Hura	al Route Number,	
	To the Hospital or Attending Physician: The within 24 hours after death, To the Funeral Director: After this certificate his completely filled in by the funeral director, page	O		ying Physician: To the best									
	the Hi in 24 the Fu	edical	one)	al Examiner: On the basis o and manner st					med at the time.				
	To To	2	29b. Signature and title of certif	ner A	n		29c. License	number		290. Date s	igned (Month,	uay, rear)	
	0,		dorune	m. Dac	ley or	P	1971	613		011	1105		
	1,		30. Name and address of person	on who completed cause of c	peath (inem 23a) (	(Type, Print	Fdui:	O Rail	ma RI	IN F	Benda	na ima	
	Sta	ite	31. Date filed (Month, Day, Yea		ar's Signature	A second	Lywi.	, ray	01 01	VCI., 10	Jourse	14/110	
	Registr		MAY 2	4 2005 Marie	J. J.	GOOM		_					

**Examiner** The law requires that the death certificate be executed burialattending physician for use as the burla Division of Vital Records, P.O. Box 68760 the detached After Diractor: in by the

To the Hospital or Attending Physician: within 24 hours a To the Funeral C

**Funeral** 

Director

iral", or Itams 23a or 28a-f show Examinar must be notified at

natural

Hygiene.

ith and Mental h Pages 1 and 2 should be in nent of Health and Mental International Street of the new S7 is marked o

= 5 permit. Page Department of Important: If any injury or

**Physician** 

/Medical

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State

(DIME) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number D15236

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

May 20, 2005

Carl I. Margolis, M.D., 11125 Rockville Pike, #211, Rockville, MD 20852

31. Date filed (Month, Day, Year) MAY 2 4 2005

d title of certifier

29a. Certified

29b. Signatu

Medical



and manner stated

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Johnson **Physician** Thomasinea 23:30 mai 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard County General Hospity Howard Colembl If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 06.11.1931 **Funeral** 1 □ M 2 XF Months Days Hours 218-28-7733 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural, or itams 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No JESSUP Director MD HOWARD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20794 USA MARYS 8760 LANE death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 2 No Specify: Specify: BLACK þ 3 NWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Hygiene COSMETOLOGIST COSMETICS 1214 GRADE .. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If item 27 is marked other t jury or other traumatic evant, to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ETHEL GARY THOMAS WILSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AMANDA JOHNSON (DAUGHTER) 12280 GREENMEADOW DR., COLUMBIA MD 21044 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State permit. Page Department of important: If any injury or once. 05.27.05 CROWNSVILLE CROWNSVILLE, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Fune a Service License an 5151 BALTO NATE PIKE , BALTO MO Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) sician Records, P.O. Box 68760 Physician/Medical phys the b attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Advanced denuella 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been si 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 NONO 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 28a. Date of Injury (Month, Day Year) the funeral 28b. Time of 28c. Injury at Work? 27 Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours af To the Funaral D completely filled in Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Silvan Hode 5005 Signal Sell Lane Clarksville

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 2 4 2005

32 Registrar's Signature

			State of Maryland / Department		-	_										
		•	1 - State Registrar Certificate		Reg.	211115	17396									
	Physici	an	1. Decedent's Name (First, Middle, Last) LINDA Johnson-Barnes		2. Date of Death Month	Day Year	3. Time of Death									
	/Medic	al		fown, or Location of Death	5 /	4c. County of Death	<del></del>									
Ш	LXamii	CI	Bon Se Cours Hospital. Ba	Itimore . M		NA										
	Funeral Director		5. Social Security Number  246 18 - 786 6. Sex  1 M 2 AF  7. Age (In yrs. last birthday) If Under 1 Months		8. Date of Birth (Month, Day, Ye 04. 26. 19	9. Birth Cou	place (State or Foreign ntry)									
	D		Usuel Residence of Decedent	V-7. 70. 1-1												
	Aaryiar f show	ō	10a. State 10b. County 10c. City, Town or Location BALLIMORE				10d. Inside City Limits 1 ■Yes 2 □ No									
	n the h	by Funeral Director	10e. Street and Number 10f. Zip (		10g.	Citizen of What Cou	ntry?									
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<b></b>	fter de r Items	Fune	1 Never Married 2 Married 1 Yes 2 No	ent of Hispanic Origin? (Spirify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Ameri Black, White,										
21215-0036	72 hours after death with the Maryland naturel', or items 23a or 28a-f show disal Evaninat roust be notified at	d by	3 ☐ Widowed 4 ☑ Divorced If Yes. Give Year or Dates:		1.00	Specify: BLA										
15-	in 72 l	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	l Occupation k done during most of work e retired)	ing	o. Kind of Business/Ir	noustry									
	ed within 'yglene.	Com	12 TH GRADE N/A OPERATO			ISSEMBLY										
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other then "naturel", or items 23a or 28a-f show or other traumatic event. The Medical Examinar must be notified at	Be	17. Father's Name (First, Middle, Last) GEORGE FISHER	MARY J	e (First, Middle, Maie OHNISONI	den Sumame)										
aryl	shoulk and Me s mark umatic	J.	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address	(Street and Number or Rura	al Route Number, Ci		Code)									
	and 2 lealth i		001 71 (7: 3) 01	RT AVE. B		21229 : Location - City or T	own State									
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Baltimore,	permit. Pages 1 and 2 Department of Health s importent: if Item 27 is any injury or other tra 90cg.			Address of Facility C. GREENE F			0.07 .40									
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	Pnysician /Medical Examiner	er	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Due to (or as a consequence of):	is nome			Interval Between Onset and Death									
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Vita	Physician: Th rithis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Other:	h (Check only one)											
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	e Hospite 124 hours 18 Funere 1etely fille	Medical C	29a. Certifier  (Check only one)  1 Dertifying Physician: To the best of my knowledge, death occurred a 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.													
<b>Y</b>	To th withir To th comp	Me	29b. Signature and title of certifier Rolls 29c.	License number	29d.	Date signed (Month,	Day, Year)									
	À		30. Name and address of person who completed cause 3 and (Item 23a) (Type. Print)	100	7 14	10	0									
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State of Maryland / Department of Health and Mental Hygiene U U 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** AMY 19 2005 May 10:20 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE Under 1 Year | If U 5251 CEDGATE RD. 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2000 Director May 18 1923 NORTH CAROLINA 093-16-1899 82 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location ltem 27 is marked other than "natural", or Itams 23a or 28a-f show other traumstic event, the Medical Examinar must be notified at 10d. Inside City Limits 1 Yes 2 □ No MARYLAND N/A BALTIMORE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5251 CEDGATE ROAD Funerai 21206 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 XNo XIX Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced Year or Dates: BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within 7 al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) LAUNDRY 8th grade PRESSER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H. sant: If Item 27 is marked oth WILLIE JUDGE MARY J. EVERETTE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Cunningham/Grandson 5251 Cedgate Road, Baltimore, Md., 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXeurial 2 ☐ Cremation 3 ☐ Removal from State injury or permit. Page Department of Important: If any injury or once. ^ 4 □ Donation 5 □ Other (Specify) MT ZION CEMETERY 05-26-05 LANDSDOWNE, MARYLAND 21. Signature of Funeral Service Lice 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cancer month -una /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed as the burial-transit and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has autopsy performed certificate 2 No 1 ☐ Yes 2 ☐ No 1 Yes al or Attending Physician: after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Yes 2 No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide To the Hospital within 24 hours a To the Funeral L Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number PHUSICIAN 19,2005 D53590 MAY BROADWAY 624 N 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHONEY DY MO 200M 609 BALTIMORE 21205 MD 31. Date filed (Month, Day, Year) 32. agistrar's Signature State

DHMH 17 Rev 1/2001

Registra

MAY 2 4 2005

		For State Registrer	State o	f Maryland /	-	tment of H		nd Mental Hy	giene Reg. No.	005	17398
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partiting Pages 1 and 2 Department of Health a Importent: If item 27 is		SE H	04.0	BROOM	Q Cr	emation a	and Fur	eral Alter			
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Physician (cate be executed by Sician and busician and the burial-transit	d	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	CANCER or as a consequent or as a consequent or as a consequent	ce of):						
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Q		30. Name and address of persor	who completed caus	e of death (Item 23	Ba) (Type, P	rint)				1	The state of the s
0		DR. TARIO MAI	MOOD 230	DULANEY	VALL	EY RD.	TIMON	IUM, MD 21	093		
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1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Reginald Tyrone Johnson, Sr. **Physician** 9.57 PM 2005 3 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Beltimore Baltmare If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** ¥ M 2□F Months 214-56-6183 55 29,1949 Maryland Director May Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits itam 27 la marked other than "natural", or Items 23a or 28e-f show other traumatic event, the Medical Eventher must be notified at Pikesville Baltimore Maryland 1 Yes 2 No Director 10f. Zip Code 21208 the ! 10e. Street and Number 10g. Citizen of What Country? 6 Trotters Court #T-2 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be illed within 72 Department of Health and Mentat Hygiene. Importent: If itam 27 is marked othar than "ne any injury or othar traumatic event, Ira Media once. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Minister Church 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruben Johnson Evelyn Dyson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly M. Johnson/ Wife 6 Trotters Ct. Pikesville, Maryland 21208 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Mary Land 5/21/05 tom State 2 ☐ Cremation 3 ☐ Removal from State Arbutus Memorial Park \* 4 ☐ Donation 5 ☐ Other (Specify) Arbutus, <del>Magyland</del> 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licen ee Zuris 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part 1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MRSA line 20 dys Sepsis /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Examine burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Year Day 5 Other (specify) ed by the a detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by End Stage Renal Discon 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Mellins 24a. Was an performed? 1 Yes 2 No 1 🗌 Yes 2XNo Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attanding 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [ Hospital 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-UUO May 13 2005 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Sinai Hospital of Bulmore MD Amera Etherinsto 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State Blown H. Agerles Registrar

Johnson, Reginald

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 8 per fh 8843 5-24-05 vt

			1 - State Registrar	State of Ma	aryland / Dep <i>Ce</i>	partment of lartificate of		Mental Hy	/giene ) 5	17400
			Decedent's Name (First, Middle, Las	t)				2. Date of De		3. Time of Death
	Physici		penalo J	en Kins				Month	Day Year	7:20 a M
	/Medio Examin	_	4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Death		4c. County of Dea	
	LXdiriii		Ruxtes Heart	en Re	heb	P. Husu	11-		Backins	-
	Funeral		5. Social Security Number 6. Se	7. Ag	e (In yrs. last birthda)		If Under 24 Hrs.	8. Date of Bir		thplace (State or Foreign ountry)
	Director		212-20-2802 1	2M 2□F	82 Yrs.	World S Days	Tiours Will.		4, <del>200</del> Mar	ylánd
-	2		Usual Residence of Decedent		10. 0it. T.					10d. Inside City Limits
	aryiar show	_	10a. State 10b. County		10c. City, Town or I	Ltimore				1 Yes 2 No
	86-1	cto	Maryland N/A	1	Da.					
3	Sa or 2	i Director	10e. Street and Number 5807 Highgate	Drive		10f. Zip Code	21215		10g. Citizen of What C USA	ountry?
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Importent: If item 27 Is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event. The Medical Examinative multiled at once.	by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ I If Yes, Give Year or Dates:	<sub>vo</sub> 1943-	. Was Decedent of If Yes, specify Cut	Hispanic Origin? (S pan, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	o- 14. Race - Am Black, Whi Specify: B1	te, etc.
2	2 ho	ted	15. Decedent's Ed		16a. Dec	edent's Usual Occu	pation during most of wor	kina	16b. Kind of Business	/Industry
-	Med "	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or s	life.	DO NOT use retire	∌d)	Killy	Self Empl	oyed
7	d with	om	2	2 Years	Tr	uck Driv	er			
and	d be file antal Hy ced othe c event.	To Be C	17. Father's Name (First, Middle, Last) Milton Jenkins					me <i>(First, Middle</i> e Hale	e, Maiden Sumame)	
Maryland 21215-0056	d 2 shoul th and Ma 27 Is marl traumati	<b> </b>	19a. Informant's Name/Relationship (1) Gloria Jones/		19b. Ma 372	ling Address (Stree	tand Number or Ru rn Drive	ural Boute Numb Balti	per, City or Town, State, LMOTE, Mary	ୟୁଟ୍ୟୁଟ 2120
altimore,	Pages 1 an ent of Heal nt: If item 7 ry or other		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State			Cem 5/2		20c. Location - City o Overlea,	
Balt	permit. Departm Importer any inju		21. Signature of Funeral Service Usen	see		22. Name and Addr 5240 Re	ess of Fa Chat istersto	man-Ha wn Rd	arris Fund Baltimore	ral Home ,Md 21215
	cate be executed / Medical Examiner street purisition and purisition and the provided in the p	ai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c.	a consequence of): a consequence of): a consequence of):	the test	oi ener	Accom	cts	Onset and Death
.O. BOX 607	The law requires that the death certificate ite has been signed by the attending physoage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	☐Ectopic pregnan	су		23d. Date of de Month	elivery Day Year
7.	that ed by deta	/ Ph	Part II. Other significant conditions of	ontributing to death b	out not resulting in the	underlying cause g	iven in Part I.	23e. Did	tobacco use contribute	to the cause of death?
S	sign sign d be	d by	Hypertunsia					1 🗆	Yes 2□No 3□F	robably 4 Unknown
Hecords,	e faw requires that has been signed b je 2 should be det	Completed	Pace melaus					24a. Was		utopsy findings available completion of cause of
		S						1 ☐ Yes	2☑No 1☐Ye	s 2 No
VItal	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Magnitale			ther	ath (Check only		
5	Physician: this certific ral director,	2	1 Yes 2 No		ent 2 ER/Outpati	GEIL 3 LI DOA			sidence 6 Other (Sp	ecify)
	fing After fune	ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ury 28b. Time uy Year) Injury	W	uryat ork? ]Yes 2∏No	28d. Describe	how injury occurred	
5	in Diffe	Certification;	3 Suicide 6 Could not b 4 Homicide determined	Zoe. Flace of III	jury - At home, farm, ic. <i>(Specify)</i>	street, factory, office	3		(Street and Number or Fown, State)	Rural Route Number,
	the Hospital hin 24 hours of the Funeral hpletely filled	ledicai (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis of and manner st	of examination and/or	ath occurred at the investigation, in my	time, date and place opinion, death occu	e, and due to the urred at the time	e cause(s) and manner a , date and place, and du	us stated. le to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date signed (Mor	oth, Day, Year)
	, 1		ceculle			0	2908	2	may 17	2005
	1/1/		30. Name and address of person who	completed cause of	death (Item 23a) (Typ					
•	4		Allan J. Ch.	~ 045 ~	-0 536	0 00	Cours 1	rees_	211	33
	St	ate	31. Date filed (Month, Day, Year)  MAY 9 4. 200		rar's Signature					

DHMH 17 Rev 1/2001

ORIGINAL

State Registrar

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

MAY 2 4 2005 DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Range Month, Day, Year)

201 East University

MSICION

32. Re mrar's Signature

30. Name an address of person who completed e of death (Item 23a) (Type, Print)

5

29d. Date signed (Month, Day, Year)

3191X

Parking Bultmore Maryland

AU417 6435 H16015 May 14,2005

	1	For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artmen <i>rtificat</i>					ene	15	17402
	1	Decedent's Name (First, Middle, Last	)						2. Date of Death		Vans	3. Time of Death
Physician	_	Gustav S.	Kurtz Sr	•					May 2	21 <sup>Day</sup>	2005	1:15 PM
/Medical Examiner		la. Facility Name (If not institution, give 2070 Kurtz Avenu				Town, or asade	Location o			Ann	inty of Death IE Arui	
Funeral Director		303-40-0031	x 7. Age	69 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. (	8. Date of Birth Month, Day 1arch U9	<sup>Year)</sup> 93(	9. Birth	place (State or Foreig intry)
D ≥ 12	⊢	Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation							10d. Inside City Limits
shore		Maryland Anne Ar	undel	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Р	asade	na				1 ☐ Yes 2 ☒ N
28a-1	3	10e. Street and Number	dildei		10f. Zip		-		10	g. Citizen	of What Cou	intry?
with a part of the	5	2070 Kurtz Avenue					21122	2			USA	
ms 2; ms 2; ms 2;	2 -	11. Marital Status	12. Was Decedent B	Ever in U.S. 13.	Was Dece				cify Yes or No-		Race - Amer Black, White	
ges 1 and 2 should be tiled within 72 hours after death with the maryland to fleath and Mental Hygiene.  I of Health and Mental Hygiene.  I of Health and Mental Hygiene.  I of Health and Mental Hygiene.  To Re Completed by Funeral Director.	5 5	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		1 Yes, spe		Specify:		iican, etc.)			nite
2 hor	3	15. Decedent's Ed	ucation		dent's Usu			st of working		6b. Kind o	of Business/li	ndustry
ed within 72 hou ygjene.  The Medical Et. The Medical Et.	2	(Specify only highest grad	College (1-4or 5	life.	DO NOT u	se retired	1)		9		D = = = #	
12 should be filed within and Mental Hygiene 17 is marked other than "fraumatic event, the Mer To Be Compile	5	12	5+		wner/	Prop					Resort	
d oth		17. Father's Name (First, Middle, Last)					11.		(First, Middle, M	aiden Sur	name)	
Ment arke	2	Gustav Kurt	_					ria	Puig			
and and sim sim sim sim sim sim sim sim sim sim		19a. Informant's Name/Relationship (7	<sub>урө, Print)</sub> (spouse		•	,			Route Number, adena, M			p Code)
m 27		Bonnie K. Kurtz	(Spouse	20b. Place of Disp			Citue	, rasc	-		on - City or T	own. State
nent of H int; If ite	1	20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □		cemetery, cre	matory or o	other plac		May	24			
tmen tent: jury	-	' 4 □Donation 5 □Other (Specify	4	Glen Hav				2009	5 4			, Maryland
Department of Health a limportent; if item 27 is any injury or other tra		21. Signature of Femeral Service Licen	21	3		1ount	ain I	Road,			Bralı z	Igme, P.A.
hysician /Medical		23a. Part1. Enter the disease, or come shock, or heart failure. List only disease or condition resulting in death)	a Meto	the death. Do not enter the de	Colo	de of dyin	Can	cardiac or	respiratory arres	st,		Approximate Interval Between Onset and Death
Examiner		Sequentially list conditions,	b									
sit ed		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):								
physician and streams transit street Examiner	ГУа	that initiated events resulting in death) Last	C. Due to (or as	a consequence of):								
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negen hould	200								04- 146		4b 14/202 200	hanny findings sysilah
page 2 s	completed								24a. Was an autopsy perform	ied?	prior to codeath?	topsy findings availab ompletion of cause of 2 No
Attending Physicien: In releath. ector: After this certificate by the funeral director, page the funeral director.	ນ	25. Was case referred to medical examiner?	I I i - I -					e of Death	(Check only one	)		
ig ig	2	1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatie			-	4 🗆 N		ne 5 X Resider			sify)
After t	5	27. Manner of Dath 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time y Year) Injury		28c. Injur Wor	k?		8d. Describe ho	w injury oc	curred	
rs after death.	runcar	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ury - At home, farm, s c. (Specify)	M treet, factor		Yes 2	100	8f. Location (Str. City or Town,	eet and N , State)	umber or Ru	ral Route Number,
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ithin 2 of the comple	Me	29b. Signature and title of certifier			29	c. Licens	e number		29	d. Date s	igned (Month	n, Day, Year)
		> muem	D.			ĭ	054	4 3			5/23	105
13		30. Name and address of person who	e 30	01 S. H	o, Print)	'er	St.	B	altim	ore	mp	21225
State		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	W							

DHMH 17 Rev 1/2001

Registrar

adolph, berhar

		For State Registrar		State of	of Marylar	-		t of He e of D	ealth and M Death		giene Reg. No.	005	17404	
		Decedent's Name	e (First, Middle	, Last)						2. Date of Dea	ath		3. Time of Death	
Physicia /Medic		Roi	nald		Ear1	K	arl,	Sr.		May 2	l, Day		4:00PM	
Examin		4a. Facility Name (/	If not institution	, give street and nu	ımber)		4b. City,	Town, or L	ocation of Death		4c.	County of Dea	ath	
				yland Hos					Clinton				eorge's	
Funeral Director		5. Social Security N 577-50-7		6. Sex 1)X M 2 ☐ F	7. Age (In yrs. 68	last birthday) Yrs.	If Under Months	Days	Hours Min.	8. Date of Birt (Month, Da Oct. 2	v, Year)		rthplace (State or Foreign country)	
and w	}	Usual Residence of	f Decedent 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits	
daryla f sho	ō	Marvland		George's		Brandy							1 ☐ Yes 2 No	
the 28a-	rect	10e. Street and Nur					10f. Zip	Code			10g. Citi	g. Citizen of What Country?		
3a or	Funeral Director	9609 Mie	ddle Ri	dge Road				20	0613			U.S.A	١.	
death	nera	11. Marital Status		12. Was Dec	edent Ever in U		Was Dece	dent of Hisp	panic Origin? (Sp , Mexican, Puerto	ecify Yes or No-		14. Race - Am		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Madical Examinet must be notified at once.	by	1 ☐ Never Marri 3 ☑ Widowed		ed 1 □Wes	2 No Kor	rean	1 🗌 Yes	•	Specify:	rican, etc./		Black, Wh Specify:	WHite	
72 ho	ted	(Snac	15. Decedent			16a. Deced	dent's Usu	al Occupati	ion Iring most of work	ina	16b. Ki	nd of Busines:	s/Industry	
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d be f	Be c	Clifford		*				'		le Atk:		Sumame		
shoul nd Me mark imati	안	19a. Informant's Na	ame/Relationsl	hip (Type, Print)		19b. Mailir	ng Address	(Street an	nd Number or Run	al Route Numbe	r, City o	r Town, State,	Zip Code)	
and 2 saith a n 27 is		Richard	E. Kar	1 (Son)		960	9 Mid	ldle F	Ridge Rd	. Brandy	wine	e, Mary	land 20613	
ss 1 a of Hei item item		20a. Method of Disp	•			Place of Dispo	sition (Nai	ne of other place)	May	Date 2.5	20c. Lo	cation - City o	r Town, State	
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permit. Departr Importa any Inju		21. Signature of Fu	uneral Service	License		22	. Name ar	nd Address	of Facility Le	ee Funei	ral l	HOme, I	nc.	
205 2 2		MA	NY	-	10019							Clintor	1, MD 20735	
1316		shock, or hea	art failure. List	complications that only one cause on	caused the deat each line.	th. Do not ent	er the mod	le of dying,	such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death	
Physician		Immediate Cause disease or condition resulting in death)		_ a//_E	-TA57	ATIC	2 (	010	NG	NUEY	2_		NOUTHS	
/Medical Examiner		. Journal of the country		/ Die to	(o as a consec	uence of):							10 ///	
	e	Sequentially list co	onditions,	b. Due to	(or as a sonesc	quenes of):								
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the de	nysic	1 □ Yes 2 [ 9 □ Unknown		9☐Unkr		364(11 3)	1 Other (s)	ecity)						
that	by Ph	Part II. Other signif	ficant condition	ons contributing to o	death but not res	sulting in the u	nderlying o	ause given	in Part I.	23e. Did to	bacco u	se contribute	o the cause of death?	
w require: been sig should b	ed b	(ORD)	NARY	ARTE	RY U,	SEASI				1 🗆 Y	'es 2	No 3□F	robably 4 Unknown	
aw requas been 2 should	piet	END	STI	IGE R	ENAL	013	EASI	E		24a. Was autop			utopsy findings available completion of cause of	
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cian: ertific ector.	Be (	25. Was case refer	rred to medical	16.11				1	26. Place of Deat		-			
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ling F	lon:	27. Manner of Cat Natural	5 Pendin	9	of Injury oth, Day Yeer)	28b. Time of Injury	M	28c. Injury a Work?	at es 2 □ No	28d. Describe h	iow injur	occurred		
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after after Dire	Certification:	4 🗌 Homicide	determ	build	ling, etc. (Specia	fy)		,,		City or Ton				
To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending i completely filled in by the funeral director, page 2 should be detached for use as	edical C	29a. Certifier (Check only one)	1 Certifyin 2 Medical	g Physicien: To the Exeminer: On the to	e best of my kno casis of examina nner stated.	owledge, death ation and/or in	n occurred vestigation	at the time , in my opir	, date and place, nion, death occur	and due to the ored at the time,	ause(s) date and	and manner a place, and du	s stated. e to the cause(s)	
To the within To the	Me	29b. Signature and	title of certifie		1		29	c. License i	number		29d. Dat	a signed (Mon	th. Dey, Year)	
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1//			is Kauk	-V			Cent	re Su	ite 207	Waldorf	, Ma	ıryland	20602	
Sta Registra	-	31. Date filed (Mon	ntn, Day, Year)		Registrar's Signa	ature	Lo	Rock						
MH 17 Rev 1/20	345			MAIZE 4	Jus Jus	due s	Cr p		N. 27					

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ORIGINAL

			1 - For State Registrar	te of Marylar			lealth and	Mental Hy	giene Reg. No. 0 0 5	17405
	Physic /Medi Exami	cal	Decedent's Name (First, Middle, Last)     Math  4a. Facility Name (If not institution, give street a.)	1 CV nd number)	9.	4b. City, Town, o	r Location of Dea	2. Date of Der Month	ath Day Year 200 4c. County of Deat	
	Funeral Director		Southern Maryland H. 5. Social Security Number 6. Sex 117 16 4213	7. Age (In yrs.	last birthday) Yrs.	Clinton If Under 1 Year Months Days	If Under 24 Hr		h 9. Birt y, Year) Co	George's hplace (State or Foreign
	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show acal Examinations be notified at	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Charles	10c. Ci	ty, Town or Lo Waldor	f		March	13, 1927 Ne	W York  10d. Inside City Limits  1 □ Yes 2√√No
	death with t	Funeral Dir	10e. Street and Number 3306 Pinefield Lane  11. Marital Status 12. Was	Decedent Ever in U	I.S. 13. )		0601 ispanic Origin? (	Specify Yes or No- rto Rican, etc.)	United Sta	ates
-0036	72 hours after dea "natural", or Itams	by	1 Never Married 2 Married 1 T		/11	TYes, specify Cuba □ Yes 2√√√No tent's Usual Occup	Specify:	rto Rican, etc.)	Specify: W	nite
Maryland 21215-0036	C * 3	Be Completed	(Specify only highest grade compl Elementary/Secondary (0-12) Coll 12	eted) ege (1-4or 5+)	life. L	kind of work done of NOT use retired	during most of wi 1) 1St			counting Off
aryland	22 should be filed within h and Mental Hygiene. 7 Is markad othar than " traumatic avant, the Med	To Be	17. Father's Name (First, Middle, Last) Stanley "Steve" Krul  19a. Informant's Name/Relationship (Type, Prin	()	19b. Mailin	g Address (Street	Jessi	ame (First, Middle, e Poteral Gural Route Numbe		ip Code)
Baltimore, M	of Healt of Healt if item 2 or other		Apolonia G. Kruk (Wii  20a. Method of Disposition  1 Burial 2 Gremation 3 Removal	20b. F	3306 Place of Disposemetery, cren	Pinefiel sition (Name of natory or other place	d Lane,	Waldorf,	Maryland 2	20601 Fown, State
Baltir	parmit. Pag Department Important: any injury o		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Liceses	M0015	22	tory May . <sub>Name and Addres</sub> lexandira	ss of Facility L	ee Funera	Clinton, Ma 1 Home, Inc nton, MD 20	: 663301d
F	Physician /Medical		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.						Approximate Interval Between Onset and Death
	Examiner	Ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	e to (or as a consequent to (or as a conseque	adenie org	SCUE!	L0515			-
.O. BOX 62	ne ray requires that the geann certificate ba executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?	s, outcome of pregna live birth 2 Fetal Pregnant at time of de Unknown	I death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of delik Month	very Day Year
ords, P	requires mai been signed t	by	Part II. Other significent conditions contributing	to death but not resu		derlying cause give	en in Part I.		bacco use contribute to es 2 □ No 3 ☑ Pro	the cause of death?
or Vital Records,		Be Completed	Abd am i val  25. Was case referred to medical examiner?  Hospital:	aorti	dise	Enoun	6. Place of De	ath (Check only on	med? death? 2. 1 ☐ Yes	opsy findings available impletion of cause of
DIVISION OF	After fune	Certification: To	27. Manner of Death  1 © Natural 5 Pending 2 Ciclient investigation	Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work M 1 \(\_\)	at ? 'es 2 □ No		ence 6 □Other (Speci ow injury occurred	fy)
= 2	ours afte		4 Homicide determined 288.	Place of Injury - At ho building, etc. (Specify the best of my know	vledge, death	occurred at the tim	e, date and place	City or Town	auga(a) and manner as a	atata d
Tothou	within 24 hours a To the Funeral I completely filled	Medical	(Onech only 2 medical examiner: On t	he basis of examinat manner stated.	tion and/or invi	29c. License	number	urred at the time, da	ate and place, and due to get and place, and due to get and place, and place and place and place and place and place and place and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and due to get and place, and place, and place, and place, and due to get and place, and due to get and place, and due to get and place, and due to get	o the cause(s)  Day, Year)
3	Sta Registr		30. Name and address of person who completed the part of the part	III A L	1911	Southern	Marylan	d Hospital E	enter Elinton	· LOUS Survatts Road MD. 20735.

			_	State of Maryland		ent of Health and		_	
			1 = For State Registrar	Otate of Marytani	•	cate of Death		2005	17406
			1. Decedent's Name (First, Middle, La	st),			2. Date of Death		3. Time of Death
	Physici /Medio		+Ingela 1	Savnoudis			Month 5	Day Year 18 2005	0130 M
	Examir		4a. Fecility Name (If not institution, give		ca Circle 4b.	City, Town, or Location of Dea	ith	4c. County of Deeth	
		V	Johns Hopkins Da	yview Care Cer	1+er	Balto. CI	ty		
и	Funeral		5. Social Security Number 6. S 216-36-0841	ex 7. Age (In yrs. I. □ M 2 □ x = 0 1	Ast birthday) If U Yrs. Mon	nder 1 Year If Under 24 Hr iths Days Hours Mir	8. Date of Birth (Month, Day, )	(ear) 9. Birth	plece (State or Foreign intry)
l.	Director		Usuel Residence of Decedent	/ / /	7		July 15	1910 0	THEEL
	ylanc		10a. State 10b. County		, Town or Location				10d. Inside City Limits
	e Ma	cto	MD		Baltimo	Re			1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number	Λ	101	. Zip Code	109	g. Citizen of Whal Cou	
	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28e-1 show he Madical Exertine transi be indiffed at	- CO	6712 Gary		2 10 111 5	21224		u.s.	
	ter de Hem Insert	in in	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in to.: Armed Forces? 1 □ Yes 2 □ Ho	S. 13. Was D If Yes,	ecedent of Hispanic Origin? ( specify Cuban Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race - Ameri Black, White	
936	urs af	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 □ Ye	es 2 No Specify:		Specify: W	Lite
21215-0036	"naturel", or	Completed by Funeral	15. Decedent's Ec		16a. Decedent's	Usual Occupation of work done during most of w	nd 16	Bb. Kind of Business/Ir	ndustry
21	within iene. than "	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	OT use retired)		_	,
	be filed within 72 ho ital Hygiene id other than "natu event, the Moolest		17. Father's Name (First, Middle, Last)			10 merrokek			ome
anc		Be	4/1/	5 Tamou / 1		18. Mother's Na	ame (First, Middle, Ma	) /	
Maryland	S should be filed within and Mental Hygiene. Is marked other than aumatic event, Ins M	2	// / Cholas =	STamoul,	19h Mailing Add	Iress (Street and Number or F	Bural Boute Number	City or Town State Zi	2 S
S	alth ar 27 io rtrau		DESTINA LOUDIS	- Daughter	72600	104645+000	+ Pall	m \ 2/	224
ē,	es 1 and 2 of Health fitem 27 r other tr		20a. Method of Disposition	20b. Pl	lace of Disposition	(Name of	Date 20	c. Location - City or T	own, State
Baltimore,	B 2 F F		1 🖺 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	Hemoval from State	Klawy C	enekul 5	123/05 7	BaltiHore	MÀ
alti	permit. Pag Department Important: any injury c		21. Signature of Funeral Service Licen			e and Address of Facility	Ender	Home, P	A .
8	Dep many per per per per per per per per per per		Hotel & Che	tell	21	34 Willow	SPING 7	Kd. 212	22
В			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	. Do not enter the	mode of dying, such as cardia	ac or respiratory arres	t.	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Alzheimer	i Dem	entia			5 years
	Examiner			Due to (or as a consequ	ience of):				
	4.	er	Sequentially list conditions,	b. Die to (or as a consequ	ier ce off:				
	te be executed ysician and se burial-transit	Examiner	Sequentially list conditions, any learning to in reclate cause. Enter Underlying Cause (Disease or injury that initiated events	C					
0,	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a consequ	ience of):				
8760	hysicithe bu	lcal		d					
x 68	leath certificate I attending physi I for use as the b	Physician/Medl	IF FEMALE:	220 If you cutoome of progress					
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 Ectop	ic pregnancy r (specify)		23d. Date of delive	ery Day Year
0	the de by the a	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		(350017)			
<u>a</u>	The law requires that the death certifica tie has been signed by the attending ph bage 2 should be detached for use as th	by Pł	Part II. Other significant conditions c	ontributing to death but not resu	ılting in the underlyi	ng cause given in Part I.	23e. Did tobac	cco use contribute to I	he cause of death?
of Vital Records,	w require been sig should b	ed t					1 ☐ Yes	2 No 3 Prot	bably 4 Unknown
ဝ၁	law requas been 2 should	Completed					24a. Was an autopsy	24b. Were auto	opsy findings available impletion of cause of
8		Com					performe	d? death? 1 ☐ Yes	
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Manual		100	eath Check on one		
of	shys this al dii	<u>۲</u>	1 Yes 2 No	Hospital: 1 Inpatient 2 E	ER/Outpatient 3 28b. Time of			ce 6 Other (Specia	(y)
	ding h. After funer	tlon	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
Division	or Attending after death. Director: Attel d in by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - At hor	me, farm, street, far		28f. Location (Street	et and Number or Rura	al Route Number,
á	al or s after of in t	Certification:	4 Homicide	building, etc. (Specify,	)		City or Town, S	State)	
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Crtifying Ph	ysician: To the best of my knowniner: On the basis of examinati	wledge, death occur	rred at the time, date and place	e, and due to the caus	se(s) and manner as s	stated.
	To the H within 24 To the Fi complete	edical	One)	and manner stated.	ion and/or investiga				
	To To	Σ	29b. Signature and title of certifier	11/		29c. License number		. Date signed (Month,	. /
		i g	Market Tel	Vito-, mo		D333/6		5//	8/2005
	3		30. Name and address of person who	completed cause of death (Item	(Type, Print)	Baggis Cin	1. Roll	in ma	7/27 (/
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat	nte (CVV)	ingules (ire	ic, pairi	non in c	1007
1	Registr		MAY 2 4 2005	Block J.	Sporte				

			1- For State of Maryland / Depar	tment of Health and M	ental Hygie	005 171.07
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	/Medic	al	Sara A. Kelly  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	May May	17 2005 11:50 A.M
	Examin	er	Fairfield Nursing Center	Crownsville		Anne Arundel
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Oct. 14,	9. Birthplace (State or Foreign Country) 1985 Maryland
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loca	ation		10d. Inside City Limits
	Maryli -f sho	tor	Maryland Anne Arundel Crownsy:			1 ☐ Yes 2 ☑ No
	th the	irec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	s 23e	rai	788 Paul Birch Drive	21032		U.S.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Integrate: If item 27 is marked other than "netural; or items 23e or 28e-f show eny injury or other treumatic event, the Medical Examinat Integrated and once.	by Funerai Director	1 X Never Married 2 Married 1 Yes 2 X No	as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto F Yes 2 X No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
200	72 hou	ted	15. Decedent's Education 16a. Decede	nt's Usual Occupation nd of work done during most of workin	168	b. Kind of Business/Industry
121	within ine.	mpie	Elementary/Secondary (0-12) College (1-4or 5+) None	O NOT use retired)	ig	N/A
ر م	filed v Hygie other I	Be Completed	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	
/lan	Mental Mental arked o	To B	Charles Kelly	Donna	A1t	
Maryland 21215-0036	12 sho h and 7 Is ma troums		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Rural		
	t Healt Healt Hem 2		20a. Method of Disposition 20b. Place of Disposit	tion (Name of D		11e, Maryland 21032  Location - City or Town, State
<u>m</u>	Pages nent of ant: If i		LA burial 2 Defination 3 Definition State 1	tory or other place)  Cemetery 5/19/	2005 Ba	altimore, Maryland
Baltimore,	ermit. Departr Inporte Ince.			Name and Address of Facility Go	nce Funer	al Service, P.A.
	20 5 9 0					nore, Maryland 21225
	Physician /Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	Wew A	rospiratory arrest,	Interval Between Onset and Death
	Examiner		"Dug to (or as a consequence of):			
7	sit s	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	cate be executed bhysician and the burial-transit	Examiner	that initiated avents resulting in death) Last			
8760,	cate be ohysicia the bur	icai	d			
39 xo	death certifica attending ph of or use as to	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		-	
O. Bo	The law requires that the death certific te has been signed by the attending p bage 2 should be detached for use as t	Physician/Medicai	in the past 12 months?	ctopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year
o.	res that the de igned by the a be detached t		Part II. Other significant conditions contributing to death but not resulting in the undi-	erlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
Records,	w requires been sign should be	ed by	Mental retardation, Suzure chio	dir	1 □ Yes	2 No 3 Probably 4 Unknown
ဝ၁	taw re nas be	Completed	, 3		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
					performed 1 ☐ Yes 2 🗸	
Vital	yslcien: us certifica director, p	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	26. Place of Death  3 □ DOA Other: 4 ¥ Nursing Hom		6 ☐Other (Specify)
0	ding Ph h. After th funeral	on: T	27. Manner of Death 1 SNAtural 5 Pending (Month, Day Year) 28b. Time of Injury		8d. Describe how in	
Division of	ttendi death. ctor: A y the fu	ertification;	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	Of Langting (Street	and Number of Division Control
<u>&gt;</u>	pital or Atten ours after deat lerel Director: filled in by the	ertif	4 Homicide determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	t, ractory, office	City or Town, St	and Number or Rural Route Number, ate)
	Ho Ho Ho Ho Ho Ho Ho Ho Ho Ho Ho Ho Ho H	edical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death of the best of examination and/or investant and manner stated.	ccurred at the time, date and place, ar stigation, in my opinion, death occurred	nd due to the cause d at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2.	Me	29b. Signature and title of partitier	29c. License number	29d.	Date signed (Month, Day, Year)
		-	· (L)///	D 389 (8	5/	17/05
	3		30. Name and address of person who completed causerof death (Item 23a) (Type, Pr	1 /	Clar D.	urnie MD 2001
	Sta	te	31. Date file (Month, Day, Year)  32. Figistrar's Signature	Mighway Sw	VUN 110	TIME THU AUU
	Registra	ar	31. Date files (Month, Day, Year)  MAY 2 4 2005  32. Figistrar's Signature	we /		

Concept Name (Institution of the post of				For Stete Registrar	State of	Marylar		artment of rtificate o				giene	005	17408
## Company of Design Control of Section 1   May 21, 2005   10:100 M				1. Decedent's Name (First, Middle	Last)								Vone	3. Time of Death
Committee   Comm				Marion King K	elly									10:10P M
Source State   Sour				4a. Facility Name (If not institution,	give street and num	iber)		4b. City, Town	n, or Location o	of Death		4c.	County of Death	
200-24-6966    Was Received of Passager   Table   Security   Table   S													lontgome	ry
Description of the control of the co										Min.	(Month, Day	v. Year)	Cou	intry)
To See and the number   To County   To C		Director			- 1	82	113.				April :	28,	1923 Wasi	nington, DC
Beamentary/Secondary (0.12)   College (1.4or 5x)   Homemaker   Own Home		land ow				10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
Beamentary/Secondary (0.12)   College (1.4or 5x)   Homemaker   Own Home		Mary -f eh lied	tor	Maryland Montgo	merv	Ret	hesda							1 ☐ Yes 2 📉 No
Beamentary/Secondary (0.12)   College (1.4or 5x)   Homemaker   Own Home		r 288	lrec			БСС	medda	10f. Zip Code	θ			10g. Citi	zen of What Cou	intry?
Beamentary/Secondary (0.12)   College (1.4or 5x)   Homemaker   Own Home		h witi	ai D	7301 Millwood	Road			2081	7			Uni	ted Stat	tes
Beamentary/Secondary (0.12)   College (1.4or 5x)   Homemaker   Own Home		deat	ner	11. Marital Status	12. Was Dece		l.S. 13.			gin? (Spec	ify Yes or No-		14. Race - Amer	ican Indian,
Beamentary/Secondary (0.12)   College (1.4or 5x)   Homemaker   Own Home	9	or Ite			ed 1 TYes	2 X No	1	_		1,1 40110 11	ilican, etc.)			, etc.
Beamentary/Secondary (0.12)   College (1.4or 5x)   Homemaker   Own Home	003	ural',	d b			tes:							Whi	
20a. Marrod of Damer (Speech) 20b Memory of D	5-		iete				(Give	kind of work do	ne during most	t of working	g	16b. Ki	nd of Business/Ir	ndustry
20a. Marrod of Damer (Speech) 20b Memory of D	12	withir ane. than	d m	Elementary/Secondary (0-12)	College (1-	4or 5+)			wed)			Оът	n Home	
20a. Marrod of Damer (Speech) 20b Memory of D	d 2	filed Hygid ther		17. Father's Name (First, Middle, L			Homen	arci	18. Mothe	r's Name	(First, Middle,			
20a. Marrod of Damer (Speech) 20b Memory of D	an	d be antal ced o	9 0		,									
20a. Marrod of Damer (Speech) 20b Memory of D	<u></u>	shoul nd Me mark	Ĕ	0	ip (Type, Print)		19b. Mailir	na Address (Stre			^	r. City o	r Town, State, Zi	p Code)
The content of the		rt 1		Alex R. Kellv/	Husband		1	-						
Projection   Pro	ē,	s 1 au f Hea item othe		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of	T	Da	ite		-	
Projection   Pro	Ë					itate Moi	ntgome	Tne	, M.	ay 24 2005		Reth	nesda M	arvland
Projection   Pro	alti	mit. partm sorts / inju				1016	R22	Name and Add	drass of Facility	Rob	ert A.	Pum	phrey Fu	iņeral Home/
23. Part I. Enter the disease or complications that cabled the death. Do not enter the mode of dying, such as cardac or respiratory arrest, photovals all aware of complications that cabled the death. Do not enter the mode of dying, such as cardac or respiratory arrest, photovals all aware of cardinal photovals of the cardinal photovals of the cardinal desiration of complications. List only one cause of each file. Do not enter the mode of dying, such as cardac or respiratory arrest, photovals all aware of cardinal photovals of the cardinal photovals of the cardinal desiration of complete desirations. The cardinal photovals of the cardi	m	99 4 8		3/01/2	Bin	M008	303 Be	thesda,	Maryla	and	20814-3	3501	wiscons	sin Avenue
Immediate Cause (Final disease or condition resulting in death)   The part of part o				23a. Part1. Enter the disease, or o	complications that ca	used the deat								Approximate Interval Between
Part   Color		Fnysician	, i	Immediate Cause (Final			Breas	t Cance	r					Onset and Death
Sequentially list conditions; gause, Enter Underlying that ministed events: "Due to (or as a consequence of): graph and the graph of th	噩	/Medical			a			· cance						
Due to (or as a consequence of):    The control of the control of	П	Examiner		Sequentially list conditions,										
See a second to the second t		pe tis	ine	cause. Enter Underlying	Due to (d	or as a conseq	luence of):							
See a second to the second t		and and Il-tran	хап	that initiated events		or as a conseq	uence of):							
FFEMALE   12% Was decedent oraginant members of personancy   12% Was decembers of personancy   12% Was decembers of personancy   12% Was decembers of personance of personance of personance oraginate members   12% Certifier   12% Ce	09,	be e	ä				, , -							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1	687	ficate p phys is the	edic		0									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1		nding use a	M/					-				2	23d. Date of deliv	ery
The state of the control of the cont		death e atte	icia	in the past 12 months?	4□Pregna	int at time of d							Month	Day Year
The state of the control of the cont	Ö.	by th	hys	9 Unknown										
243. Was an autopsy performed? 1   Yes   2   No  246. Was a autopsy friedings available prior to completion of cause of death? 1   Yes   2   No  25. Was case referred to medical examiner? 26. Place of Death (Check only one)  27. Manner of Death 1   Natural   5   Pending investigation   28a. Date of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Describe how injury occurred   28b. Location (Street and Number or Rural Route Number, City or Town, State)  28b. Place of Injury   28b. Describe how injury occurred   28b. Location (Street and Number or Rural Route Number, City or Town, State)  29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Dey, Year)   29d. D	Ś	gned gned be de		Part II. Other significant condition	ns contributing to de	ath but not res	ulting in the u	nderlying cause	given in Part I.		23e. Did to	bacco u	se contribute to t	he cause of death?
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Dey, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Kenneth Goldstein, M.D. 2141 K Street, N.W., #707, Washington, D.C. 20037	18	deatl deatl ctor: y the	fica	3 ☐ Suicide 6 ☐ Could no	ot be 200 Place	of Injury - At he	ome, farm, str				Bf. Location (S	treet and	d Number or Rur	al Route Number.
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Dey, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Kenneth Goldstein, M.D. 2141 K Street, N.W., #707, Washington, D.C. 20037	D.	after Dire	erti	4  Homicide	buildin	g, etc. (Specif	(y)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
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29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Dey, Year)  May 23, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Kenneth Goldstein, M.D. 2141 K Street, N.W., #707, Washington, D.C. 20037		n 24 n 24 he Fu	edic	(Check only 2   Medicel E	xeminer: On the ba	sis of examina er stated.	ition and/or in	estigation, in m	y opinion, deat	th occurred	d at the time, d	date and	place, and due t	o the cause(s)
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Kenneth Goldstein, M.D. 2141 K Street, N.W., #707, Washington, D.C. 20037  State Registrar MAY 2 4 2005		3												
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		Dhi.i.i		1. Decedent's Name (First	st, Middle,	Last)						2. Date of Dea	ith Day	Year	3. Time of Death
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		Examin		4a. Facility Name (If not it	institution,	give street and no	ımber)		4b. City, Town	n, or Locat	ion of Death		4c. County	of Death	
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		Funeral Director		5. Social Security Number		3. Sex 1  M 2  F XX		rs. last birthday) Yrs.	If Under 1 Ye Months Day		irs Min.	8. Date of Birtl (Month, Da)	r, Year)		lace (State or Foreign try)
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		er de	Funerai	11. Marital Status		Armed F		10.S. 13.	Was Decedent of If Yes, specify C	of Hispanio Suban, Mex	Origin? (Sp cican, Puerto	ecify Yes or No- Rican, etc.)	14. Rad Bla	ce - Americ ck, White,	
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	br	be filed within 7: ntal Hygiene. od other then "n. event, the M.o.	Be C	17. Father's Name (First,	Middle, L	ast)				18. M	lother's Nam	e (First, Middle,			
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	Maryland	s 1 and 2 should be filed within thealth and Mental Hygiene. Item 27 is marked other then "other treumatic event, the Massian and the treumatic event, the Massian and the treumatic event, the Massian and th	113	19a. Informant's Name/F								al Route Numbe			
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E	Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other tree	113	20a. Method of Disposition 1√2 Burial 2 ☐ Cre		<b>V</b> Removal from		o. Place of Dispo cemetery, crea MARY	sition (Name of natory or other (	olace)		Date	20c. Location	- City or To	wn, State
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		Physician		Immediate Calle (Final disease or condition resulting in death)		_ a	1)ei	nen	iA						Jene
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2		xecurand al-train	xar	that initiated events resulting in death) Last		c. Due to	(or as a cons	equence of):						_	
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7	687	eath certificate be executed attending physicien and for use as the burial-transit	hysician/Medicai			d.									
MAY	Вох	nding use a	M	IF FEMALE: 23b. Was decedent preg	nant	23c. If <u>y</u> es, ou			_				23d. Da	te of delive	ry
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	ď.	The law requires that the death certificate be executed its has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	by P	Part II. Other significant	condition	s contributing to	leath but not i	resulting in the u	nderlying cause	given in P	art I.	23e. Did to	bacco use conf	tribute to th	e cause of death?
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	n of	ding Ph h. After th funeral		27. Manner of Dati	Pending	28a. Date	of Injury oth, Day Year,	28b. Time of Injury	28c. in	njury at Work?		28d. Describe h			noop ree
5	Division	utendir death. ctor: Af y the fu	ertification;	2 Accident	investiga	tion		,,		☐ Yes 2	2 □No				
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micHAE		the Hospitel or Attending I nin 24 hours after death. the Funerel Director: After npletely filled in by the funer	edicai	(Check only 2 1	Certifying Medical E	Physician: To the taminer: On the t	pasis of exam	nowledge, deatlination and/or in	n occurred at the restigation, in m	e time, date y opinion.	e and place, death occurr	and due to the c	ause(s) and ma	anner as sta	ated. the cause(s)
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		on on one	-	29b. Signature and title o	Certifier	M		0	Sac. Fice	) 🦳 +	-20 J		9d. Date signe		ZOOU
	,			14/1	M	1 long	Kr	4,0	w /	1					•
		5		30. Name and address of	person w	ho completed cau	se of death (I	lem 23a) (Type,	Print)			601 N. (			et
		Sta	6	31. Date filed (Month, Da	y, Year)	32.	agistrar's Sig	gnature			T	owson, N	1D 2120	4	
		Registra	_		-	2005	BLINE	K A	راليد						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year 11:20 A M 23 2005 Bednarczyk Krokos May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6713 Duluth Avenue Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 214/20/7400 78 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "netural", or Items 23a or 28e-f show the Madical Example: .ust be notified at L□Yes 2□No Directo Maryland NA Baltimore 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 6713 Duluth Avenue 21224 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No ģ 3 € Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Nurse Continental Can Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill timent of Health and Mental H lant: If item 27 is marked oth Be Bednarczyk Stella <u>Marcinisk</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes K. Seifert ( Daughter ) 1747 Trout Farm Road Jarrettsville, Md. 21084 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department o important: if any injury or once. 5 \* 4 ☐ Donation 5 ☐ Other (Specify) Crematory Inc. May 24,2005 Baltimore, Maryland Bayview 21. Signature of Funeral Service Lie 22. Name and Address of Facility W. Dabrowski/Chojnacki Funeral Homes P.A. 1005 Dundalk Ave. Raltimore, Maryland that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enfer the disease, or complication shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician once year /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has performed certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ 1 🗌 Yes this After this funeral of 27. Mann f Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification; 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funerel C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie ) aran 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 2 4 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year Silas C. Loy Sr. 23 May 2005 4:30a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8911 Warfield Road Montgomery Gaithersburg If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1[XM 2□F Yrs. 214-32-4799 71 31, Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8911 Warfield Road 20882 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 XYes 2 No
If Yes, Give
Year or Dates:1956-58 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☒ No Specify: 3 XWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic 8 Montgomery County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lancelot C. Loy Lucille Nichols 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Silas S. Loy Jr./Son 27525 Mout Radnor Drive, Damascus, Maryland 20872 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5/24/2005 1 ☐ Burial 2 ØCremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematorium Inc. Alexandria, Virginia 21. Signature of Juneral Service LIC 22. Name and Address of Facility
Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocardial infarction acute Due to (or as a consequence of): A D 30 years

Pnysician /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

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Completed

**Funeral** 

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryiar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itama 23a or 28a-1 show any injury or other traumatic event, the Madical Examinat must be notified at

Baltimore, Maryland 21215-0036

sician and burial-transit

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phys. the b To the Hospital or Attending Physician: this After within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu

Division of Vital Records, P.O. Box 68760.

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n: To Be Completed by Physician/Medical	1 2
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Sequentiary list conditions, fi any, leading to immediate Due to (or as a consequence of):									
cause (Disease or injury that initiated events resulting in death) Last	c. Arterioscle  Due to (or as a consec		30 + years						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1	al death 3 □Ectopic	pregnancy (specify)		23d. Date of de Month	l slivery Day Year			
Part II. Other significant conditions co		sulting in the underlying	g cause given in Part I.	23e. Did tobacc		o the cause of death?			
				24a. Was an autopsy performed	? death?	utopsy findings available completion of cause of s 2 No			
25. Was case referred to medical			26. Place of De	eath (Check only one)					
examiner? 1 🔀 Yes 2 🗌 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 X Residence	6 ☐Other (Spe	ecify)			
27. Manner of Death  1   SNatural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how in					
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fact	ory, office	28f. Location (Street City or Town, St	and Number or R ate)	ural Route Number,			
29a. Certifier 1⊠ Certifying Phy (Check only 2  Madical Exam	rsicien: To the best of my known iner: On the basis of examination and manner stated.	owledge, death occurrent ation and/or investigati	ed at the time, date and place on, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner a and place, and du	s stated. e to the cause(s)			
29b. Signature and title of certifier	ala m		29c. License number  D 00/09	43 M	Pate signed (Mon.	th, Day, Year) 4, 2005			

Saia MD 1201 Seven Locks Road, Suite 202 Rockville, Maryland 20854

State Registrar Jøhn S.

at Date filed (Month, Day

and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygierie Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month MAY **Physician** 2885 EDWARD COULTER LONG 6:05 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Examiner Saint Joseph Medical Center Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Bay, Year) July 22, 1918 **Funeral** 9. Birthplace (State or Foreign Months 11XM 2□ F Days Hours 214-12-4225 Maryland 86 Director Usual Residence of Decedent with the Maryland r than "naturel", or itema 23a or 28a-f show the Medical Examinar must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 60 Murdock Road 21212 **USA** death Funerai 12. Was Decedent Ever in U.S. Amped Forces? VIXYes 2 □ No WW I If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry filed within 72 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "ne any injury or other traumatic event, the Modie. Once. Elementary/Secondary (0-12) College (1-4or 5+) Lineman Telephone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Coulter Long Grace Leona Keelen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John P Hull Attorney 10 East Baltimore, Street Baltimore MD 21202 20a. Method of Disposition

XX Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Parkwood Cemetery 5/31/05 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Anature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CHRONIC RENAL FAILURE YEARS /Medical Due to (or as a consequence of): Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical as the l IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 Yes 2 No 1 🗌 Yes the Hospitei or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 X No 1X Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending Injury after death. 1 Tyes 2 No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 To the F 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D 25886 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE, MARYLAND LILIA CEBALLOS. M. D. TOWSON. 31. Date filed (Month, Day, Year) 32. Resistrar's Signature Registrar

			1 - For State Registrar	State of	Maryla	nd / Depa	artmen rtificate			and M	lental Hy	giene		de der	7413
	Physic /Medi		1. Decedent's Name <i>(First, Middle, La</i> Oak In	•							2. Date of Do Month MAY	eath 19 <sup>Da</sup>	<sup>y</sup> 2005	ar	Time of Death .0:45a M
	Exami		4a. Facility Name (If not institution, given Mariner of Nort	ne street and number h Arunde	ber) 1				Location of Burn			40	. County of D Anne	eath	
	Funeral Director		5. Social Security Number 6. S 217-19-8898  Usual Residence of Decedent	Gex 7 1 □ M 2 1 F	. Age (In yrs	90 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bi (Month, Di FEB 17	th ay, Year), $19$		Birthplace ( Country) Corea	(State or Foreign
	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or itams 23a or 28a-f show or other traumatic event, the Medical Evantra	Funeral Director	10a. State 10b. County	Arundel	10c. C	city, Town or Lo	10f. Zip		n Buri	nie		10g. Cit	izen of What	1	nside City Limits □Yes 2ሺNo
	ath wit	ralD	313 Hospital Dr					1061					South	Korea	a
920	urs after de al', or Itams Evantrer n	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	es? Γ <b>X</b> No		Was Deced f Yes, spec 1 ☐ Yes 2		spanic Orig n, Mexican, Specify:	in? (Spe , Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Al Black, W Specify:		
21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4	or 5+)	life. I	dent's Usua kind of wor DO NOT us memak	k done d e retired)	urina most	of worki	ng		ind of Busine	ss/Industry	
73	2 should be filed within and Mental Hygiene. Is marked other than aumatic evant, the Me	To Be Co	17. Father's Name (First, Middle, Last, Chong Pu Lee	)		110	memer.				(First, Middle		Surname)		
Man	d 2 sho h and 7 Is mu trauma		19a. Informant's Name/Relationship (						nd Number	r o <i>r Rur</i> a	l Route Numb	er, City o		, Zip Code	)
	Pages 1 and 2 nant of Health int: If Item 27 iry or other tra		Kihong Stone/Dar 20a. Method of Disposition 1 Burial 2X Cremation 3	Removal from St	ate	Place of Dispo cemetery, cren	natory or ot	e of her place	)	D	nton, M	20c. Lo	ocation - City	,	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 Is any injury or other tra <u>once</u> .		21. Signatur of Funeral Service Licer		l Me	tro Cre	Name and Cremat	Address	of Facility SOC16	etv	of MD.	Inc	ltimor		)
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	Medical Examiner  bhysician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any heads I membrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a consec	pute quence of):	MST	n			5-2-2			y	uars
.O. Box 68	It the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outco 1 □ Live birtl 4 □ Pregnan 9 □ Unknow	n 2 □ Feta tattime of o	aldeath 3 🗌	Ectopic pre Other (spe						23d. Date of d Month	elivery Day	Year
rds, P	signed signed d be de	leted by PI	Part II. Other significant conditions o	ontributing to deat	h but not res	sulting in the un	derlying ca	use giver	n in Part I.		23e. Did t	1	se contribute		se of death?
		Complet									24a. Was autor perfo 1  Yes		24b. Were a prior to death?	completio	dings available on of cause of
	Physician: this certition al director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	atient 2	ER/Outpatient	2000	Other	2.4		(Check only o			7	-
	ding h. After funer	atlon; T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of I (Month,		28b. Time of Injury		c. Injury a		2	ne 5 ☐ Resid 8d. Describe h			өсіғу)	
É	i gig e	Certification	3 Suicide 6 Could not be determined	building	etc. (Speci						8f. Location (S City or Tox	vn, State)			Number,
	e Hospital 24 hours a a Funeral l letely tilled	edical	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the be niner: On the basi and manner	s of examina	owledge, death ation and/or inv	occurred a estigation, i	t the time in my opi	, date and nion, death	place, a occurre	nd due to the d d at the time,	cause(s) date and	and manner a place, and du	as stated. Je to the ca	iuse(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier			2	29c.	License		-			signed (Mor		
	./	t	30. Name and address of person who d	completed cause of	of death (Iter	m 23a) (Type F	Print)	D	951	2		may	120	20	21061
	5		SANG C, Doff, M. 31. Dat MIGHT (MORITH, Pay, Xear)	D, 160	o Cra	in High	way	. Su.	Te 2	06	Gran	BYA	WIE	MDo	21061
	Sta Registr	4.0	THE PROPERTY OF THE PROPERTY O	Blosus 32. Heg	strar's Signa	Sozet .	/								/

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Joseph B. Lloyd 2005 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death North Arundel Hospital Glen Burnie 8. Date of Birth (Month, Day, Year) 71 9,1934 Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1**⊠** M 2□ F 214 30 9764 Director 71 Yrs Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 ☐ Yes 2 No Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 311 W. Arden Road 21225 U.S. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 전 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Machinist Roper Venetian Blinds 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph B. Lloyd Sr. Anna Lambert 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: if item 27 is eny injury or other treu once. Donna Lloyd / Wife 311 W. Arden Road Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 📆 Cremation 3 ☐ Removal from State Bayview Crematory ` 4 ☐ Donation 5 ☐ Other (Specify) 5/25/2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. 22. Name and Address of Facility 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Ran1. Enter the disease, of complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):

Physician /Medical **Examiner** 

ortant: If item 27 is marked other than "natural", or items 23e or 28e-f show injury or other treumatic event. The Madical Examinat must be notified at

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if item 27 is marked other than '

TOSEPA

burial-transit Director:

To the Hospitel or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

tical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  C	yay a	erse.		
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
	Part II. Other significant conditions of	ontributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tobacco	- 4	o the cause of death?
Completed				24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of 2 No
Be	25. Was case referred to medical examiner?		26. Place of De	eath (Check only one)		
To	1 ☐ Yes 2 No	Hospital: Impatient 2 ER/Outpatient	3 DOA Other: 4 Nursing	Home 5 Residence	6 □Other (Spe	cify)
	27. Manner of Feath 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how inj	ury occurred	
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28f. Location (Street a City or Town, Sta	and Number or Ru te)	ıral Route Number,
Medicai (	29a. Certifier (Check only one) Madical Exam	ysician: To the best of my knowledge, death of hiner: On the basis of examination and/or inveand manner stated.	occurred at the time, date and place stigation, in my opinion, death occ	ce, and due to the cause( curred at the time, date ar	s) and manner as nd place, and due	stated. to the cause(s)
ž	29b. Signature and title of certifier		29c. License number	29d D	ate signed (Mont	h Day Vons

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

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within 24 hours at To the Funerel D completely filled in

29b. Signature and title of certifier

Choken 31. Dale filed (Month, Day, Year)

D43977 May 20 21 We, Chan Birmit. ms 206. 32. Registrar's Signature

person who completed cause of death (tem 23a) (Type, Prince) 30/

State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY Day **Physician** Year ROBERT LEVY 20 2005 6:54 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD Funeral 6. Sex 1 M M 2 ☐ F 7. Age (In yrs, last birthday) Days 216-09-5099 88 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-fahow in than "natural", or items 23a or 28a-f ahov the Medical Examinar must be notified at Director 1 ☐ Yes 2 ☐ No BALTIMORE RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4010 CARTHAGE ROAD 21133 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forcey? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White et within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No WHITE Specify 3 Nidowed 4 □ Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 ANIMAL KEEPER CITY OF BALTIMORE marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 Is marked any injury or other traumatic ev SIMON ဥ UNKNOWN SARAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALAN LEVY / SON 1900 UPPER FORDE LANE - HAMPSTEAD, MD 21074 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State <sup>1</sup> 4 □ Donation 5 □ Other (Specify) BETH HAMEDROSH 05/23/2005 ROSEDALE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** teriosclerosis 20 4900 resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examiner and burial-t Due to (or as a consequence of) Box 68760, the attending physician Physician/Medical as the IF FEMALE: use use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. I ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 9 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed Deen tenosis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page ; certificate 2 12 No 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 K ER/Outpatient 3 DOA After th 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation within 24 hours after common to the Funerel Director: After common and the funerel birector of the funerel fulled in by the funerel fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5/21/05 D0020964 30. Name and iddress of person who completed cause of death (Item 23a) (Type, Print) 8630 Liberty Plaza Mall Randallstown, MD 21133 M.D. <u>Jerome H. Ginsberg,</u> 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 2.4 2005

		1 - State Registrar		-	artment of Health and ertificate of Death	F	Reg. No. 005	17416
Physi		1. Decedent's Name (First, Middle, CATHERINE M.				2. Date of Dea Month	Day Year	3. Time of Death
/Med Exam	dical niner				4b. City, Town, or Location of Dea		9, 2005 4c. County of Dea	1350 P <sup>*</sup>
		4a. Facility Name (If not institution, 2209 ASHBURTON	STREET		BALTIMORE CITY			ila
Funera Directo		5. Social Security Number 211 · 20 · 1981  Usual Residence of Decedent	6. Sex 7. Agr 1 ☐ M 2 🕻 F	e (In yrs. last birthday 85 Yrs.	If Under 1 Year If Under 24 Hr Months Days Hours Min		9. Bi	nthplace (State or Foreign country) VA
nyland how		10a. State 10b. County	ı	10c. City, Town or L	ocation			10d. Inside City Limits
8a-fs	Director	MD N	N	BALTIMO	RE			1 Yes 2 No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exaction or that be multipled at mone.		10e. Street and Number 2209 ASHBURTO	N STREE	Ī	10f. Zip Code 21216		log. Citizen of What C	ountry?
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2 short and his ma		19a. Informant's Name/Relationshi		19b. Maili	ng Address (Street and Number or F		r, City or Town, State,	Zip Code)
1 and Health Sm 27 ther to		HELEN PAYSOUR  20a. Method of Disposition	(NIECE)	3050 20b. Place of Dispo	GRANTLEY AVE.,	BALTO. 1		
ages ant of h it: If ite y or of		1 ■ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		cemetery, cre	matory or other place)		20c. Location - City of	Town, State
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		resulting in death)	Due to (or as a	consequence of):	ic Wellow In	6-10	scare	
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death certificate be executed  a attending physician and ind for use as the burial-transit	by Physician/Medical Examiner	Sequentially list conditions, 1 any, leaving to limited ause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Cue to (or as a d. Cue to (or	of pregnancy	Other (specify)		Month pacco use contribute t	Day Year the cause of death?
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The law requires that the death certificate be executed at the las been signed by the attending physician and page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical Examiner	Sequentially list conditions,  Tary, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	b. Due to (or as a d. Due to (or	of pregnancy    Fetal death   5	Other (specify)nderlying cause given in Part I.	1 Yes 24a. Was a autops perform 1 Yes ath (Check only on	Month  pacco use contribute to as 22 No 3 Prior to death?  24b. Were a prior to death?  No 1 Yes	Day Year  o the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of
The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	e Completed by Physician/Medical Examiner	Sequentially list conditions,  any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	b. Oue to (or as a d. Due to (or	of pregnancy    Fetal death   5	Other (specify)  nderlying cause given in Part I.  26. Place of De out 3 DOA	24a. Was a autops perform 1 Yes ath (Check only on Home 5 Reside	Month  pacco use contribute to as 22 No 3 Prior to death?  24b. Were a prior to death?  No 1 Yes	Day Year  o the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAY 2 4 2005

29c. License number

OCME

111 Penn Street Baltimore Maryland 21201

29d. Date signed (Month, Day, Year)

MAY 19, 2005

			1 = For State Registrar	State of iv	flaryland / Depa Cei	artment o <i>rtificate</i>			-	ene	05	17417
	Physic		1. Decedent's Name (First, Middle, Last Leven son	)			Ho.	ody	2. Date of Death Month Hay	Day 20	Yeer 2005	3. Time of Death
· ·	/Medi Examii		4a. Facility Name (If not institution, give The Johns Hope	6.7	ospital	Balt	imo	ation of Death		7	nty of Death	
	Funeral Director		5. Social Security Number 6. Se 249-46-9389  Usuel Residence of Decedent	X 7. A	ge (In yrs. last birthday) 72 Yrs.	If Under 1 Y Months D		Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day, 10/08/		9. Birthple Count SC	ece (State or Foreign ry)
Maryland 21215-0036	nd 2 should be filed within 72 hours after death with the Maryland aith and Mental Hygiene. 27 is marked other than "naturel", or items 23s or 28e-f show reaumatic event, the Medical Examers must be notified at	To Be Completed by Funeral Director	10a. State 10b. County  MD Baltimo  10e. Street and Number  857 N Avondale Ro  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Ed. (Specify only highest grade  Elementary/Secondary (0-12)  10  17. Father's Name (First, Middle, Last)  Henry Moody  19a. Informant's Name/Relationship (Ty.  Barbara Sue Moody	ad  12. Was Deceden Amped Forces 1 [Xif Yes, Give Year or Dates: cation c completed)  College (1-4or	JNo Joan Joan John John John John John John John Joh	10f. Zip Co 212.  Nas Decedenti f Yes, specify i □ Yes 2≅  dent's Usual of kind of work d DO NOT use n e	2 2  t of Hispar Cuban, M. You Spurceupation lone during etired)	exican, Puerto pecify:  g most of worki  Mother's Name Sarah Bi  Number or Rura	acity Yes or No-Rican, etc.)	U.S. 14. RB Specific	A.  Jace - America lack, White, et ity:  Business/Indual Gove	un Indian, otc. ack ustry ernment
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic e once.		20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens	lemoval from State	20b. Place of Disposementery, crem Crownsvi	sition (Name of natory or other lle Ve . Name and A Crematic	of r place) t. Ce ddress of l on and	emetery Facility d Funera	May 27 2005	Oc. Location  Crowns  atives	n - City or Tow Sville,	m, State  Maryland  ryland 2128
	Physician but sicial pe executed / Medical Examiner street	edical Examiner	23a. Part1. Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	d the death. Do not ente line.	or the mode of	dying, suc	ch as cardiac o Cancen yndso	r respiratory arres	st,		Approximate Interval Between Onset and Death Swks
. BOX	death certiff e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	Ectopic pregni Other (specify		**			eate of delivery	/ Day Year
cords, r	law requires that the de as been signed by the 2 should be detached	þ	Part II. Other significant conditions cor	tributing to death t	out not resulting in the un	derlying cause	given in I	Part I.				cause of death?
_	The larate has	e Completed	25. Was case referred to medical							24b	Were autops prior to comp death?	ry findings available pletion of cause of No
	Physicien: rthis certific ral director,	0	examiner?	ospital:	ent 2 ER/Outpatient	3□ DOA			(Check only one) ne 5 ☐ Residen	re 6 🗆 01	thar (Specific)	
DIVISION OF	After fune	Certification; T	27. Manner of Death  Natural 2 Accident 3 Suicide 4 Homicide  2 Pending investigation 6 Could not be determined	28a. Date of Inju (Month, Da	ury 28b. Time of	28c. (	njury at Work? 1  Yes	2   No	8d. Describe how 8f. Location (Stre City or Town,	injury occu	erred	Route Number,
	To the Hospitel or Attentwithin 24 hours after deall To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one)  Certifying Phys 2 Medical Examir	ician: To the best ler: On the basis o and manner st	of my knowledge, death of examination and/or invitated.	occurred at the	ie time, da ny opinion	ite and place, a	nd due to the cau d at the time, date	se(s) and m	nanner as stat , and due to th	ed. ne cause(s)
	within To the comp	Σ	29b. Signature and title of certifier	H.D		Re	ense num	0 0 0	1	_	ed (Month, Da	
1	Sta		30. Name and address of person who con ANITHA NALLU, H.D., 31. Date filed (Month, Day, Year)	JOHNS H	death (Item 23a) (Type, F forking Hos rar's Signature	PITAL,	600,1	WORTH (	WOLFE S	TREET,	BALTIMO	DRE, MO 21287

		For State Registrar	State of	Marylar		artment of H tificate of L		and Mer		eņe g. No. 0	5	17418
Physici	an	1. Decedent's Name (First, Middle, Last				4.11		2.	Date of Death $_{ m 18}^{ m Month}$ ,	Day _	Year	3. Time of Death
/Medic		Barbara		Lynn		Miller			ıy 18,	2005	-4 D11	23:15PM M
Examir	er	4a. Facility Name (If not institution, give Southern Mary				4b. City, Town, or Clin		of Death		4c. County		orge's
Funeral		5. Social Security Number 6. Se	7		last birthday)	If Under 1 Year	If Under 2	24 Hrs. 8.	Date of Birth		9. Birth	place (State or Foreign
Director		216-64-1164	]M 2√∑F	51	Yrs.	Months Days	Hours	Min. M	Date of Birth (Month, Day, lay 22,	1953	Mary.	land
P P		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					Т	10d. Inside City Limits
Maryle f sho	ō	Maryland Anne Ar	undel		Lothia							1 ☐ Yes 2 🛣 No
the 1	rect	10e. Street and Number				10f. Zip Code			10	g. Citizen of \	What Cou	intry?
h with	al D	69 Edwards Lane				20	711			U	.S.A	•
partillior; Mai yiallia ( Z. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Dat	es? TVNo	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Orig n, Mexican Specify:	gin? (Specify , Puerto Rica	Yes or No- an, etc.)		k, White. آما	ican Indian, , etc. hite
72 ho	Completed	15. Decedent's Edu (Specify only highest grad			16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most	t of working	1	6b. Kind of B	usiness/lr	ndustry
Nen "	mpie	Elementary/Secondary (0-12)	College (1-	for 5+)	1	ро Not use retired ce Clerk	)	· · · · · · · · · · · · · · · · · · ·		Verizo	n	
Hygie Hygie ther ti		10th  17. Father's Name (First, Middle, Last)		<del></del>	OIII	Je Glerk	18. Mothe	r's Name (F	irst, Middle, M			,
d be d be bental ked o	To Be	William Lloyd	Bond	urant				anor	Bondu		,	
shoul Mind Mind Mind Mind Mind Mind Mind Mind	-	19a. Informant's Name/Relationship (7)	pe, Print)		19b. Mailir	ng Address (Street a		Table 10 miles of the latest			State, Zi	p Code)
i, Mal		Eleanor C. Slavin	(Mothe	r)	444	Avanti W	ay Bl		art or the state of the state o			
es 1.2		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	temoval from S	ate	cemetery, crei	sition (Name of natory or other plac	Θ)	Date May 20	` -	Dc. Location -		
Delicition  Permit. Pages Department of P  mportent: If It  any injury or of		*4 □ Donation 5 □ Other (Specify)  21. Signature 9 Funeral Service License				ematory 2. Name and Addres		2005		linton		
Physician /Medical		23a. Faut. Enter the disease, or comp shock, or heart failures. List only of Immediate Cause (Final disease or condition resulting in death)	ications that canno cause on ea	ch line.	th. Do not ent	33 Old A	lexan	dria F	spiratory arres	oad Cl		n , MD 20735 Approximate Interval Between Onset and Death
cate be executed when the physician and the burial-transit and	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	3	r as a consec								
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usines that a signed b	by	Part II. Other significant conditions co	ntributing to dea	ith but not res	sulting in the u	nderlying cause give	en in Part I.			cco use cont 2 □ No	nbute to t	the cause of death?
Vital necolus, sicien: The law requires certificate has been signs rector, page 2 should be	Completed								24a. Was an autopsy perform	24b. 1	death?	opsy findings available ompletion of cause of
icien: 1 icien: 1 sertificat ector, pi	Be C	25. Was case referred to medical examiner?						of Death (C	heck only one			
this and	2	1 ☐ Yes 2 ☑ No			ER/Outpatier		4 🗆 Nu	-	5 🗀 Residen			<i>(y)</i>
ding f	ion	27. Manner of Death  1 Natural 5 Pendivg  2 Accident investigation	28a. Date of (Month	, Day Year)	28b. Time o Injury	Worl	k? Yes 2 □!		. Describe hov	r injury occur	90	
or Attending fler death. Director: After in by the fune	ertification:	2 Accident Investigation 3 Suicide 6 Coul not be 4 Homicide determined	e. Place of building	of Injury - At h g, etc. <i>(Speci</i>	nome, farm, sti ify)	eet, factory, office			Location (Stre City or Town,	eet and Numb State)	er or Rur	ral Route Number,
To the Hospitel or Attending Physicien: The Within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical Ce	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam		is of examina								
ro the vithin ro the comple	Me	29b. Signature and title of certifier				29c. License	e number		29	d. Date signe	d (Month,	Day, Year)
->F°	$\Lambda$	1		1		D00	286	39		5-19	-00	5
1 1		30. Name and address of pirson who c	ompleted cause	of death (Ite	m 23a) (Type,						- (	4.12
Sta Regist		Ze Phirin, Jacques 31. Date filed (Month, Day, Year) MAY 2	4. M.D. S 32. Re 4 2005	gistrates Sign	n Naryla ature	nd Hospital	Center	, 7503	Surratt	5 Road, [	linto	n,MD 20735
				P-SCHOOL ST		7		10.77				

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND TIFM #18 PER FH C843 5/26/05 and ifficate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 5:40pMildred E. McConnell 2005 MAY 18. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2√2F 212-01-7407 94 Director JUL 15. Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Directo Maryland Baltimore Timonium 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2300 Dulaney Valley Road Apt. W201 21093 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify. White 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Secretary Dime Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland Be Thomas R. McConnell Urik .MAY FLIZABEIH ROSENBERGER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Importent: If Item 27 is n any injury or other traun once. 11 N. Hilltop Road Catonsville MD 21228
ce of Disposition (Name of Date 20c. Location - City or Town, State Ruth O. Head/friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Metro Crematory, Inc. 5/19/05 Baltimore, MD \* 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Coasses

Dawn F. McDonald 22 Name and Address of Faculity
Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tracomial hemovolinge, secondary 10 days **Physician** /Medical Due to (or as a consequence of): To Fall with Head trauma Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 X No 24a. Was an perform 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 □ No 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Fall 5 Pending investigation 1 Natural 1 ☐ Yes 2 📉 No 2 Accident 3 Suicide May 9, 2005 iours after death.
nerel Director: A 1000 A 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

187. Certifying Physician: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

286. Location (Street and Number or Rural Route Number, City or Town, State)

287. Location (Street and Number or Rural Route Number, City or Town, State)

288. Location (Street and Number or Rural Route Number, City or Town, State)

289. Location (Street and Number or Rural Route Number, City or Town, State)

280. Location (Street and Number or Rural Route Number, City or Town, State)

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281. Location (Street and Number or Rural Route Number, City or Town, State)

282. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funerel C 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MAY 19,2005 106266 , uno 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 N. Charles Street Towson, MD 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAY 2 4 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

NeCannell

JET 05-03458 Unk

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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cno	own V DEREK		1 - For State of Maryland		artment of H			gienel U Reg. No.	5	1146	2-1
	Divi-i		1. Decedent's Name (First, Middle, Last)				2. Date of De	ath Day	Year	3. Time of	Death
	Physici /Medic		Steven Derek Marsh				May	18 2	.005	6:00	Р
1	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		Death	4c. Count	y of Death	/ A	
			153 N. E11wood Ave.  5. Social Security Number 6. Sex 7. Age (In yrs. la	st hirthday)	Baltimon	CE If Under 24	4 Hrs. 8. Date of Birt	h	N/	A place (State o	or Foreign
	Funeral Director		195-48-9847 X™ 2□F 48		Months Days	Hours	Min. MAR 14,	<sup>9</sup> 1957	Ohi	ntry)	" · or orgin
	σ		Usual Residence of Decedent								
	show	'n		, Town or Lo		imore				10d. Inside Ci 11∑1Yes	2 No
	the N	Director	Maryland N/A		10f. Zip Code	THOLE		10g. Citizen of	What Cou	7.	
	3a or		153 N. Ellwood Avenue		2122	4		USA		, .	
036	72 hours after death with the Maryland "netural", or iteme 23a or 28a-f show olical Examiner must be nutilled at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S Armed Forces?  1 Never Married 2 Married  11. Was Decedent Ever in U.S Armed Forces?  1 Never Married 2 Married  12. Was Decedent Ever in U.S Armed Forces?  1 Never Married 2 Married  12. Was Decedent Ever in U.S Armed Forces?		Was Decedent of H f Yes, specify Cuba  □ Yes 2 No		in? (Specify Yes or No Puerto Rican, etc.)	- 14. Ra Bla Speci	ck, White,	can Indian, etc. White	
2-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Decec	dent's Usual Occup	ation during most o	of working	16b. Kind of E	Jusiness/Ir	ndustry	
21215-0036	d within 72 ho piene. r than "netui Ine Medical	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	DO NOT use retired	)		Rail:	road		
121	filed w Hygier Ather tl		12 17. Father's Name (First, Middle, Last)	111	spector	18 Mother	s Name (First, Middle,				
and	ed its b	To Be	Derek George Marsh				Beryl Maler				
Maryland		F	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street		or Rural Route Numbe			Code)	
ž	1 and 2 Health a tem 27 is		Derek George Marsh/Father		y Terrac		lsmar, FL	34677			
ore			20a. Method of Disposition 1 ☐ Burial 2 【***Cremation 3 ☐ Removal from State 20b. Pta	ace of Dispo- metery, cren	sition (Name of natory or other place	9)	Date	20c. Location	- City or T	own, State	
Ē	Pages Iment of tent: if it jury or o		`4 □Donation 5 □Other (Specify) Metr		matory, 1		5/20/05		imor	e, MD	
Baltimore,	permit. Page Department of importent; if any injury or once.		21. Signature of Euneral Service Ocensee  Edward A. Gregorchik	2 2	remation 99 Frede	Societick R	ty of MD, oad Baltii	Inc. more, M	D 212	228	
	ar.		23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ente	er the mode of dyin			•		Approximate Interval Bett Onset and I	ween
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	Examiner		Sequentially list conditions b.								
	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ence of):							
ζ_	cate be executed obysician and the burial-transit	Examine	that initiated events resulting in death) Last  Due to (or as a consequi	ence of):							
8760,	sician buria	icaj E									
687	ificate g phy: as the	ed	O								
.O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burral-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal in the past 12 months? 4 □ Pregnant at time of decent in the past 12 months?	death 3	Ectopic pregnancy Other (specify)				ate of delivi onth	,	Year
rds, P.	g B	by	Part II. Other significant conditions contributing to death but not result	ting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use con	tribute to t		leath? Jnknown
Vital Records,	The law te has b age 2 sl	Completed							Were auto prior to co death? 1/X Yes	opsy findings ampletion of ca	available ause of
/ita	ician: Certifica	Be C	25. Was case referred to medical examiner?				of Death (Check only o	ne)			
of \	Physician: this certific al director,	70	21	R/Outpatien	the second second	4 🗆 14015	sing Home 5 Resid			y) Scen	e
		ertification	1 □Natural 5 □ Pending (Month, Day Year)	28b. Time of Injury	28c. Injun Worl M 1 🗍		28d. Describe h	ow injury occur	Ted +	COLL	į.
Division	ten leat tor: the	ficat	Could not be 28e. Place of Injury - At hor	ne, farm, str			28f. Location (S	Street and Num	ber or Run	i Route um	ber,
Ω	or Direction	erti	4 Aomicide determined building, etc. (S airy)	THO	4		City or Tow	n, State	Dorl	fire 21	1224
	of the part of the	edical C	29a. Certifier (Ch + only on )  1 Certifying Physician: To the best of my know Medicel Examiner: On the basis of examination of states.	rledge, death	occurred at the tin						)
	To the Hos within 24 ho To the Fun completely	Me	29b. Signature and title of certifier		29c. License	number		29d. Date signe	d (Month,	Day, Year)	
			M Stortenio)		OCM	E	N	May 19 2	2005		
	3		30. Name and address of person who completed cause of death (Item	23а) (Туре,							
			J. LA RON LOYLE, MY)		111 Pe	nn Str	reet Baltin	nore Man	:ylan	d 2120	1
	Sta Registr		31. Date filed (Month, Day, Year)  32. Begistrar's Signate		arle						
DH	MH 17 Rev 1/20	94	MAY 2 4 2005 Days &	7. Ago							

		1 - For State Registrar	State of	Marylar				ealth a Death	and M		Reg. No.	005	17422
Phys		<ol> <li>Decedent's Name (First, Middle, Edward Jackson</li> </ol>								2. Date of De May 18	ath Day	05 Year	3. Time of Death 9:15 PM
/Me Exan	dical niner	4a. Facility Name (If not institution,	give street and numi	ber)	·	4b. City,	Town, or	Location o	f Death			County of Deati	1
Funer Directo		717 Maiden Choi 5. Social Security Number 6 219-05-0151			last birthday) Yrs.		atons 1 Year Days	of Under 2 Hours		8. Date of Bir (Month, Da July 1	th v. Year)	Co	oplace (State or Foreign untry) ryland
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mantal Hygiene. The All marked other than "naturel", or thems 23a or 28e-1 show other treumette event, the Maxical Exercities in until the notified at	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  Baltin  10e. Street and Number  717 Maiden Choi  11. Marital Status  1 Never Married  15. Decedent's  (Specify only highest  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, La  George Metz  19a. Informant's Name/Relationship  Katherine H. Me  20a. Method of Disposition	Ce Lane Stame Stamed Force  12. Was Deced Amed Force 1 ⊠Yes 2 If Yes, Give Year or Date  Education grade completed)  College (1-4) 2  st)  (Type, Print)	GT221 lent Ever in Ures? In No les: WWI.	I 16a. Deced (Give life. I Insu 19b. Mailir 717 M	was Decedif Yes, specific Yes, specific Yes, specific Yes and the Yes and the Yes and the Yes and the Yes and the Yes and Address and Address as the Yes and Address as the Yes and Ye	21228 dent of Hi crity Cubai 22 No al Occupa rk done of se retired, a (Street a	spanic Origin, Mexican Specify: attion furing most Lesman 18. Mothe Ind Numbe	of working  n  r's Name  Marie  or Or Rura	cify Yes or No Rican, etc.)	10g. Citi. U.S.	zen of What Col  A.  14. Race - Amer Black, White Specify: Wh nd of Business/I  11state Sumame)  Town, State, Z	10d. Inside City Limits 1 □ Yes 2 ☑ No untry? ican Indian, b, etc. ite industry Insurance
t. Page rtment o rtent: If njury or	al er	1 🗷 Burial 2 Cremation 3 14 Donation 5 Other (Spe 21. Signature of Funeral Service Lie 23a. Part 1. Enter the disease, or coshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	profile and the composition of the cause on early one cause on early Due to (o	St.	John 1 22 ith. Do not ent	s Cer S Cer Ster 736	neter  nd Addres  ling  idmor	s of Facility Ashto	5/21/ y on Sc Aver cardiac o	/2005 chwab F nue; Ca r respiratory a	Elli uner	cott Ci	ty, Maryland Inc. MD 21228 Approximate Interval Between Onset and Death
The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that imitiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant condition	d	th 2 ☐ Feta nt at time of d vn	ancy al death 3 [ death 5 [	Ectopic p	pecify)	on in Part I.		23e. Did t		3d. Date of deline Month	very Day Year the cause of death?
VICAL INCOLLOSY, stclen: The law requires the contificate has been signed lirector, page 2 should be continued.	se Completed by	Cardiomyox  25. Was case referred to medical			g vice ul		gird			1 1 24a. Was autop	an osy ormed?	No 3 ☐ Pro	opsy findings available ompletion of cause of
ng Phy Iter this	Certification: To B	examiner?  1 Yes 2 Yo  27. Manner of Death  1 Yatural 5 Pending 2 Accident investiga 3 Suicide 6 Could no 4 Homicide	28a. Date of (Month)	Injury Day Year)	28b. Time of Injury	M	28c. Injury Work 1 □ \	at	-2 No	8d. Describe	how injury		ral Route Number,
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edicai Cert	29a. Certifier 1 Certifying	Physician: To the basiner: On the bas	est of my kno	owledge, death	occurred vestigation	at the tim	e, date and	d place, a	nd due to the	cause(s)	and manner as place, and due	stated. to the cause(s)
To the within 2 To the complet	Med	29b. Signature and title of certifier	and manne	n stated.		29	. License	number			,	signed (Month	
15×1		30. Name and address of person w	Bowlin completed cause		<i></i>	Print) 1		377 een	Bo	wlin,	mi	20/20 5	٥٥٥
Regi	State strar	31. Date filed (Month, Pay Year)	2005 32	gistrar's Signa	ature A	and a	5		, v(W	V 1:	0		

		-	For State Registrar	State of I	Maryland		artment of H			jiene og. No.	05	17423
	۰		Decedent's Name (First, Mid	idle, Last)					2. Date of Deat Month	th Day	Year	3. Time of Death
	Physicia /Medic		STANLEY	I.			MINCH		MÄY		2005	1:35 A M
	Examin		4a. Facility Name (If not institut	tion, give street and number	er)		4b. City, Town, or	Location of Death		4c. Co	unty of Death	
			HOSPICE OF B					TOWSON			BALT	
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/10/1	Year)	9. Birthi	olace (State or Foreign ntry)
	Director		218-28-9967 Usual Residence of Decedent		78	110.			12/10/1	1920		<u>MD</u>
	land ow		10a. State 10b. Cour	nty	10c. City,	Town or Lo	ocation					10d. Inside City Limits
	Mary -fsh fied	to	MD	N/A	BAL	TIMOF	RE					1 Yes 2 □ No
	r 28e	Funerai Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen	of What Cou	ntry?
	23a (23a)	ai	200 CROSS KE				21210				U.S.A.	
	r dea	nei	11. Marital Status	12. Was Decede Armed Force	s?	13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Ameri Black, White,	
36	hours after death with the Maryland tural', or Items 23a or 28e-f show al Esaninar must be notified at	by Fi	1 ☐ Never Married 2 🛣 M 3 ☐ Widowed 4 ☐ Divord	If Yes, Give	_		1 ☐ Yes 2 🂢 No	Specify:		Sp	ecity: WH	ITE
21215-0036	72 hours after death with the Marylan Insturel; or items 23a or 28e-1 show Jigal Examiner must be notified at	edt		dent's Education		16a. Dece	dent's Usual Occupa	ation		16b. Kind	of Business/Ir	dustry
15	in 72	Completed	(Specify only hig Elementary/Secondary (0-12	hest grade completed)	or 5+)	life.	kind of work done of DO NOT use retired	)	ing	CHIZ	UK AMUI	NO
212	d within giene. or then "	E O	Elementary/Secondary (6 %	4		EXEC	JTIVE DIRE				REGATIO	ON
	be filed within 72 hc ital Hygiene. id other then "natul avent, IV Me Jiral	Be (	17. Father's Name (First, Midd					18. Mother's Name		Maiden Sui		
Maryland	should be and Mental marked o	70	HARRY	LOUIS		MIN		THERESA			HILKO	
Jar	2 shd and is m		19a. Informant's Name/Relation				ng Address (Street a					
	s 1 and 2 should of Health and Men item 27 is marke other treumatic		JUNE MINCH / 1 20a, Method of Disposition	WIFE	20b. Pla		CROSS KEYS				tion - City or T	
ŏ	0 0		1 Burial 2 ☐ Crematic	on 3 Removal from Sta	ate cen	netery, cre	matory or other plac	05/22				
Baltimore,	permit. Pag Department Important: i any injury o		* 4 □ Donation 5 □ Other  21. Signature of Funeral Set		CHIZ	UK AN	2. Name and Addres		L LEVINS		IMORE,	
Ba	permit. Departm Imports any inju		1/200	1			3900 REIST	30				MD 21208
			23a. Part1. Enter he disease	, or complications that cau List only one cause on eac	sed the death.	Do not en	ter the mode of dyin-	g, such as cardiac	or respiratory arr			Approximate Interval Between
	Physician		Immediate Cause (Final	LIST OTHY OTHE CAUSE OF BAC	DA	no	reation	c CAY	reek			Onset and Death
	/Medical		disease or condition resulting in death)	aDue to (or	as a conseque							•
	Examiner		Sequentially list conditions.	b		4)			.,			
1	sit s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseque	nce of):						
<b>b</b>	ate be executed hysician and the burial-transit	хап	that initiated events resulting in death) Last	c Due to (or	as a conseque	ence of):						
8760,	be e	icai E										
687	ficate physics the	9		d								
Вох	leath certifica attending phi i for use as Ih	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnand		⊒Ectopic pregnancy			23d	. Date of deliv	
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 □ Yes 2 □ No		t at time of dea		Other (specify)				Month	Day Year
P.0	that the de ed by the detached	hys	9 Unknown				4.4.5	and in Board	230 Did to	shacco use	contribute to	the cause of death?
	res that signed to be det	by	Part II. Other significant con-	ditions contributing to dear	th but not resur	ling in the t	inderlying cause give	en in Parti.	1 □ Y	\		bably 4 □Unknown
Records,	w requir been si should	Completed							24a. Was a		14b Ware sut	ones lindings available
3ec	elaw has b	mple							autop:	sy med?	death?	opsy findings available ompletion of cause of
a	sicien: The law certificate has b irector, page 2 s		25 111-	direct .				OC Place of Deel		202No	1 🗆 Yes	2 □ No
Vital	Physicien: rthis certifica ral director, I	Be c	25. Was case referred to med examiner? 1 ☐ Yes 2 No	Hospital:	atient 2   E	R/Outpatie	nt 3 DOA Oth	er: 4 Nursing H	ome 5 Resid		Other (Speci	(fv) Hogpine
of	Phy rthis	To To	27. Manner of Death	28a. Date of (Month,		28b. Time o			28d. Describe h		-	W Hospice
lon	nding F ith. r: After e funera	ation	1 Natural 5 Per 2 Accident inv	nding (Month, estigation	Day (Gai)	Injury		Yes 2 □No				
Division	Attendi ar deeth. rector: A by the fu	Certification:		uld not be ermined 28e. Place of building	Injury - At hom	ne, farm, st	reet, factory, office		28f. Location (S City or Tow	treet and N m, State)	Number or Rui	al Route Number,
	itei oi irs aft rei Di											
	To the Hospitei or Attending within 24 hours after deeth.  To the Funerei Director: After completely filled in by the fune	edical	29a. Certifier 1 Certi (Check only 2 Medi	fying Physician: To the b cal Examiner: On the bas and manne	is of examination	tedge, dea on and/or in	th occurred at the tin evestigation, in my o	ne, date and place, pinion, death occui	and due to the or red at the time, or	ause(s) an date and pla	ace, and due	stated. to the cause(s)
	the of the orthodorn	Med	29b. Signature and title of cep		/ Stated.		29c. Licens	e number	2	29d. Date s	signed (Month	Day, Year)
	N N N		1 M 4	Allrus 11	Ily.	M	02	2062		ma	Ly 20	2005
	16		30. Name and address of per	son who completed cause	of death (I)em :	23a) (Type	, Print)				narles	·
	1,4		W. A.	Riley							21204	
	Sta	ate	31. Date liled (Month, Day, Ye	ear) 32. Reg	gistrar's Signatu	ire en						
	Regist	rar	MAY 24	2005	J.	Const	2		_			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vaar Physician MAY 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY ROCKVILLE HEBREW HOME OF GREATER WASHINGTON If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country)
 PA 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 🛚 F 80 209-14-1183 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or itams 23a or 28a-f show other traumatic event, the Medical Experiment dust be notified at 1X Yes 2 No ROCKVILLE MONTGOMERY Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 20852 U.S.A. 6121 MONTROSE ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes 2 No Specify: Specify If Yes, Give Year or Dates: Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME **HOUSEWIFE** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **CHERNOFF** ROSENTHAL FANNIE **JACK** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13213 JASMINE HILL TERRACE - ROCKVILLE, MD 20850 GLEN MELTZER / SON 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ROOSEVELT CEMETERY 05/23/2005 TREVOSE, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical HYPERTENSION **Examiner** Seventially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner burial-transit to tha Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 attending physician the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐ Unknown 5 Other (specify) P.0. 9 Unknown atributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 20 No 2D No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Yoursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification; To 3□ DOA 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Naturai 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To tha Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

5

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

# Registrar's Signature

sici: edic	an	Decedent's Name (First, Middle, La	ast)							2. Date of				3. Time of Death
			NESMITH-							Month MAY	2	Day 2 2	Yeer 005	12:32 A <sup>M</sup>
min	er	4a. Facility Name (If not institution, gir		nber)		4b. City, T	Fown, or	Location o	of Death		4	4c. County	of Death	
		GILCREST HOSPIC	E Sex	7 Aga (In up In-1)	6 t-46 -t- 1	BA If Under 1		MORE	0411			BAL	TIMOR	
al or		///X-X/-//////////////////////////////	1 □ M 2XX¥F	7. Age (In yrs. last i	Yrs.		Days	Hours	Min.		Day, Yea	ar) 1942	9. Birthpla Count SOUT	ace (State or Foreign ry) 'H CAROLIN
		10a. State 10b. County		10c. City, To	wn or Lo	cation							10	d. Inside City Limits
	tor	MARYLAND HARFO	RD CO.		JOI	א סכ								1 ☐ Yes 2XXVo
	Director	10e. Street and Number	KD CO.		001	10f. Zip 0	Code				10g. C	Citizen of W	hat Count	rv?
		304 OAKWAY COU	RT				2108	35				U.S.2	A .	1
	Funeral	11. Marital Status	12. Was Dece Armed For	dent Ever in U.S.	13.	Was Decede f Yes, specif	ent of His	panic Orig	gin? (Spe	cify Yes or	No-		- America	
	by Fu	1 ☐ Never Married ※X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Giv	2 ( <b>X</b> No e		I ☐ Yes 2		Specify:	, 1 00110 1	noan, otc.)			, White, e	
	ed t	15. Decedent's E	Year or Da		- Passa	lent's Usual	0						BLAC	
	Completed	(Specify only highest gr	ade completed)		(Give	kind of work DO NDT use	done du retired)	uring most	of workin	ng	16b.	Kind of Bus	siness/Indu	ustry
	EO	Elementary/Secondary (0-12)	College (1			wife						DOMEST	PTC	
	Be	17. Father's Name (First, Middle, Last	)					18. Mother	r's Name	(First, Midd		en Sumame		
	2	ALSTON NESMITH					İ	MA	RY NI	ESMIT	H			
		19a. Informant's Name/Relationship (	Type, Print)	19	b. Mailin	g Address (	Street ar	nd Number	r or Rural	Route Nur	nber, City	or Town, S	state, Zip C	Code)
l		Sylvia Stuart/Day	ughter	4	17 I	LARKSP	UR I	DR.,			2108	35		
l		20a. Method of Disposition 1 X Hurial 2 ☐ Cremation 3 ☐	Removal from S	State 20b. Place cemet	of Dispo: ery, crem	sition (Name natory or oth	e of er place	)	Da	ate	20c. I	Location - C	ity or Tow	n, State
l	1	` 4 ☐ Donation 5 ☐ Other (Specif	y)			LS ME				8-05	MII	DDLE F	RIVER	, MARYLAN
		21. Signature of Funeral Service Lice	1500		WM	Name and ICBR	NWO	COMMI	UNITY	Y FUNI	ERAL	HOME-	HARF	ORD, P.A. . 21001
ı		23a Part1. Enter the disease, or com shock, or heart failure. List only	plications that ca	used the death. Do	not ente	or the mode	of dying,	such as c	ardiac or	respiratory	arrest,	TUDDDL	A	Approximate nterval Between
		Immediate Cause (Final disease or condition		netas										Onset and Death
ı		resulting in death)	W	or as a consequence										gran
1					01):								1 1 1	0
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	cal Examiner	that initiated events	Due to (c	or as a consequence	of):									
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	dicai	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	Due to (c  c	or as a consequence or as a consequence ome of pregnancy th 2 □ Fetal deat	of):	Ectopic preg	gnancy					23d. Date	,	
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	by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 € No	Due to (c.  Due to (c.  d.  23c. If yes, outc.  1 Live bir.  4 Pregna  9 Unknow	or as a consequence or as a consequence or as a consequence one of pregnancy the 2 Petal death of the string of death which are consequences.	o of):  o of):  n 3	Other (spec	eify)	in Part I.				Monti	n Da	ay Year
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DHMH 17 Rev 1/2001

12:32am

Mary

Nesmith- Gwynn

			1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death  Reg. No. 0 5 1 7 4 2 (	5
	Dhusia		1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat	h
	Physic /Medi		Evelyn May Norkus Month Day 7:25 p	М
	Exami	ner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Deeth  And And And And And And And And And And	Pel
*	Funeral Director		5. Social Security Number 217-07-2132  Usual Residence of Decedent  6. Sex 92 Yrs.  1 M 2 F 92 Yrs.  1 M 2 F 92 Yrs.  1 M 2 F 92 Yrs.  1 M 2 F 92 Yrs.  1 M 2 F 92 Yrs.  1 M 2 F 92 Yrs.  1 M 2 F 92 Yrs.  1 M 2 F 92 Yrs.  1 M 2 F 92 Yrs.  1 M 2 F 92 Yrs.  1 M 2 F 92 Yrs.  1 M 2 F 92 Yrs.  1 M 2 F 92 Yrs.  1 M 2 F 92 Yrs.  1 M 2 F 92 Yrs.  2 M Min.  3 Days Hours Min.  3 Days Hours Min.  4 Min.  4 Min.  4 Min.  5 Days Hours Min.  5 Days Hours Min.  5 Days Hours Min.  7 Age (In lyrs. last birthday)  9 Birthplece (State or Fore Country)  MD  1 M 2 F 1 M 2 F 1 M 2 F 1 M 2 M 2	эign
	yland		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lim	nits
	Mar a-f st	to	MD Anne Arundel Glen Burnie	No
	th the	lrec	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	23a	ai	318 5th Avenue S.E. 21061 U.S.A.	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Medical Exeminer must be notified at	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1	
Š	2 hou	ted	15. Decedent's Education 16a. Decedent's Usual Occupation 15b Kind of Revisional Indiana.	
21215-0036	filed within 7. Hygiene. ther then "n.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0·12)  10  (Give kind of work done during most of working life. DO NOT use retired)  Sales  Montgomery Wards	
	be file Ital Hy Id othe	Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	
/lai	2 should be and Mental is marked o	10	William Rohde Nellie Ann Duvall	
Maryland	2 sho and is m		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
	s 1 and if Health itam 27 other tr		Mrs. Jill Fleisher / niece 285 Inverrary Road, Pinehurst, NC 28374	
Jor	00		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State	
Baltimore,		( )	'4 Donation 5 Other (Specify)  Glen Haven Mem. Park May 23,2005 Glen Burnie, MD  21. Signature-of Trail Seguine Licenses Company Compa	
Ba	permit. Departiments Importiments any inj	(2 G	21. Signature of Facility Singleton Funeral Home P.A.  1 Second Avenue S.W., Glen Burnie, MD 21061  23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate	
	Physician /Medical Examiner	ner	shock, or heart failure. List only one cause on sach line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
8760,	death certificate be executed e attending physician and id for use as the buriat-transit	Icai Examine	Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):	
9	ing ph	Med	IF FEMALE:	
P.O. Box		Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 25 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Month Day Year	
	90 00	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown	۷N
Division of Wital Records,	ician: The law certificate has b rector, page 2 sl	Completed	24a. Was an autopsy findings availab prior to completion of cause of death?  25. Was case referred to medical	le i
3	/sicia s cert directs	o Be	examiner? 25. Place of Death (Check only one)	
0	g Physier this neral di	T.	27. Manner of Death  28a. Date of Injury  28b. Time of  28c. Injury at  28d. Describe how injury occurred	-
jo	Attending Physician: r death. ector: Ater this certific: by the funeral director,	atio	Natural 5 Pending (Month, Day Year) Injury Work?  2 Accident investigation M 1 Yes 2 No	
Divis	5 gire	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	To the Hospital within 24 hours a To the Funeral I completely filled	ledical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	ſ	X	29b. Signature and (title of certifier  29c. License number  29d. Datersigned (Month, Day, Year)  29c. License number  29d. Datersigned (Month, Day, Year)	
	Q Sto		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  LOF:  BUHTTY, 3VI HOS pital Dr., 61an [Swnit, m]  31. Date filed (Month, Day, Year)  32. Registrar's Signature	
Direction	Stat Registra	ar	MAY 2 4 2005 Medice to Spark	
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ORIGINAL

		Decedent's Name (First, Mid-	dle. Last)								2. Date of De	ath			3. Time of Death
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Medica camine		4a. Facility Name (If not instituti			oer)	<del></del>	4b. City, 7	Town, or	Location of	of Death	MAY		ounty of De		U. 00 A
		Howard County	Genera	al Ho	spital	L	1	olum					Howar	d	
eral ctor		5. Social Security Number 125-03-7721	6. Sex 1 ☐ M		. Age (In yrs. 92	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Sept.	27, 19	9. E 12 Ne	Birthpla Country W Y	ce (State or Fore y) ork
12	}	Usual Residence of Decedent  10a. State 10b. Count	ty		10c. Ci	ty, Town or Lo	ocation							100	d. Inside City Lim
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erot	Directo	10e. Street and Number					10f. Zip	Code				10g. Citize	n of What	Countr	y?
dian.	rai	3004 N. Ridg						1043					·S.A.		
Die	Funerai	11. Marital Status	12. W	was Decede	ent Ever in U	J.S. 13.	Was Decede If Yes, speci	ent of His ify Cubar	spanic Ori n, Mexican	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	o- 14	. Race - Ar Black, W		
Tage 1	þ	1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce	lf.	Yes 2 Yes, Give Year or Date	_		1 ☐ Yes 2	X No	Specify:			S	pecify:	W	hite
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State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - For State Registrar Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) May <sup>D</sup>2005 **Physician** 19 Betty Jean Roche 11:35 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death **Examiner** Citizens Nursing Home Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🖾 F Yrs. February 1930 Director 220-26-2427 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location or 28a-f show the Madical Examiner roust be notified at 1 ☐ Yes 2X No Director New Market Frederick Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21774 than "natural", or Itams 23a U.S.A. 5716 Yeagerstown Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: δ Specify: 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Office Worker Hospita1 init. Pages 1 and 2 should be filed indication of Health and Mental Hygis ortant: If itam 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Culler Mary E11en Houck Kurtz A. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Eva E. Wahl - Sister 5716 Yeagerstown Road, New Market, Maryland 21774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition ☐ Burial 2 「Cremation 3 ☐ Removal from State ☐ Dpnation 5 ☐ Other (Specify) Metropolitan Crematorium 5/21/05 Alexandria, Virginia 4 ☐ Donation pemit.
Departri
Importa
any inju 21. Signature of Fu eral Sector License 22 Name and Address of Facility Olin L. Molesworth P.A., Funeral Home vert 26401 Ridge Road, 20872 Damascus, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) stryden Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-transit that initiated events resulting in death) Last signed by the attending physician and I be detached for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy in the past 12 1 Tes 2 Month 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 3 Probably 4 □Unknown 2 No Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No this certificate 1 Yes Division of Vital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: Hospital: 1 Yes Nursing Home 5 Residence 6 Other (Specify) No 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Manger of Death Certification; After Injury 5 Pending investigation **Natural** М 1 ☐ Yes 2 ☐ No death. Accident after death filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours a To the Funaral I Hospitel 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and on 2005 30. Name and address of person who completed cause f death (Item 23a) (Type, Print) Robert L. Kaufmann M.D. 300 300 West 9th Street, Frederick, Maryland 21701 31. Date filed (Mon A) 2005 State Registrar

1. Tregister Service (1984) 1. Description of the control of the c		State of Maryland / Department of Health ar 1- Store Amend Item# 20b, per FH, 6843, 5/27/05 Con Death			005	17429
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FFEMALE: 23b. Was decedent pregnant in the past 12 months?   1   ves 2   No 3   Probably 4   Pregnant at time of death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contribute to the cause of death?   1   ves 2   No 3   Probably 4   Popplant at time of death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contribute to the cause of death?   1   ves 2   No 3   Probably 4   20h known autopay gentlement?   1   ves 2   No 3   Probably 4   20h known autopay gentlement?   1   ves 2   No 3   Probably 4   20h known autopay gentlement?   1   ves 2   No 3   Probably 4   20h known autopay gentlement?   1   ves 2   No 3   Probably 4   20h known autopay gentlement?   1   ves 2   No 3   Probably 4   20h known autopay gentlement?   25e. Was case referred to medical example of the past of th	хап	that initiated events C.				
FFEMALE:   23c. If yes, outcome of pregnancy   1   Uve birth   2   Fefal death   3   Ectopic pregnancy   1   Ves   2   Nonth   Day   Year   1   Year   2   2   Nonth   Day   Year   1   Year   2   2   Nonth   Day   Year   1   Year   2   Nonth   Day   Year   1   Year   2   Nonth   Day   Year   1   Year   2   Nonth   Day   Year   1   Year   2   Nonth   Day   Year   1   Year   2   Nonth   Day   Year   1   Year   2   Nonth   Day   Year   1   Year   2   Nonth   Day   Year   1   Year   2   Nonth   Day   Year   1   Year   2   Nonth   Day   Year   1   Year   2   Nonth   Day   Year   1   Year   2   Nonth   Day   Year   1   Year   2   Nonth   Nonth   Day   Year   1   Year   2   Nonth   N	<u>a</u>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1	as the	V				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1	esn W/u	23b. Was decedent pregnant 23c. If yes, outcome or pregnancy 3 Ectopic pregnancy				
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24a. Was an autopsy findings available prior to completion of cause of death (Specify)  25. Was case referred to medical examiner?  1   Yes 2   No   Hospital:   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)  27. Manner of Death   28a. Date of Injury   28b. Time of Injury   28c. Injury at   Work?   28d. Describe how injury occurred  29a. Certifier   Check only one)  29a. Certifier   Check only one)  29b. Signature and title of certifier   29b. Signature and title of certifier   29b. Signature and title of certifier   29b. Signature and title of certifier   29b. Signature and defension of the sais of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier   29b. Signature and title of certifier   29b. Signature and title of certifier   29b. Signature and title of certifier   29b. Signature and title of certifier   29b. Signature and title of certifier   29b. Signature and title of certifier   29b. Signature and title of certifier   29b. Signature and title of certifier   29b. Signature and title of certifier   29b. Signature and title of certifier   29b. Signature and title of certifier   29b. Signature and title of certifier   29b. Signature and title of certifier   29b. Signature and title of certifier   29b. Signature   29b.	Phy	9 Unknown	222	Did tobacca		the serve of death?
24a. Was an autopsy performed?  25. Was case referred to medical examiner?  1   Yes   2   No   28. Place of Death (Check only one)  27. Manner of Death   28. Describe how injury occurred  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Month, Day Year)  28. Date of Injury   28. Injury at   28. Inju		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
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25. Was case referred to medical examiner?	mpl			autopsy	prior to o	itopsy findings available completion of cause of
1   2   Accident   2   Accident   3   Suicide   4   Homicide   4   Homicide   5   Pending investigation   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   29a. Certifier (Check only one)   2   Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   32-Registrar's Signature   32-Registrar's Signature   32-Registrar's Signature   32-Registrar's Signature   32-Registrar's Signature   33-Registrar's Signature   34-Registrar's Signature			1 🗆 Y	es 2 No	1 🗆 Yes	212(No
1   Natural 2   Accident 3   Suicide 4   Homicide 4   Homicide 5   Pending investigation 6   Could not be determined 5   Suicide 4   Homicide 5   Suicide 5   City or Town, State)	Be	examiner?			. 50	
2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 29a. Certifier (Check only one) 29b. Signature and title of certifiel 29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filled (Month, Day, Year) 32e Registrar's Signature 3 State 3 Suicide 4 Homicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (State) (State) (State) (State) (Sta	Ę.	To a zigno To impatient zo evolupatient 30 DOA 47 Nursi				city)
29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filled (Month, Day, Year)  32e Registrar's Signature	at lo	M 1 Vac 2 Ala				
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filled (Month, Day, Year)  32-Registrar's Signature	ifica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office	28f. Locati	on (Street ar	d Number or Ru	ıral Route Number,
29a. Certifier (check only one)  29a. Certifier (check only one)  29a. Certifier (check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Cert	unitality, etc. (Specify)	Ony o	70mm, State	'/	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  560 Loch Kaven Blod, Ballinole, 164 - 21239.  State 31. Date filed (Month, Day, Year)  32-Registrar's Signature	cal	29a. Certifier (Check only (Ch	place, and due to	the cause(s)	and manner as	stated.
30. Name and address of person who completed cause of death (Ijem 23a) (Type, Print)  500 Lock Lover Blod, Bolling, 16d - 21239.  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	npfete <b>fedi</b>	one) and manner stated.				
State 31. Date filed (Month, Day, Year) 32-Registrar's Signature	2	290. Signature and title of certifier D 306	61	HM.	u 200	£ 2005
State 31. Date filed (Month, Day, Year) 32-Registrar's Signature				100	1	
State 31. Date filed (Month, Day, Year) 32-Registrar's Signature	5	50. Name and address of person who completed cause of death (them 23a) (Type, Print)	, Id	- R	123	7.
gistrar MAY 2 4 2005	State	31. Date filed (Month, Day, Year) 32 Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Rice **Physician** 430 Max Q Emi 7005 /Medical 4b. City. Town, or Location of Death 4a Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner Home If Under 1 Year utheran 100 awn more If Under 24 Hrs 8. Date of Birth (Month, Day) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. lest birthday) Months **Funeral** Days 1□M 2XF Hours South -530 217-22-530 Usuel Residence of Decedent Director Carolina deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28e-f ehor traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Completed by Funeral Director Varyand to 10e. Street end Number timor 10f. Zip Code 10g. Citizen of Whet Country? 32 "naturel", or items 23e es d 21 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14 Race - American Indian 11. Marital Status permit. Peges 1 end 2 should be filed within 72 hours efter c Depertment of Heelth end Mentel Hygiene. Important: If Item 27 is marked other than "naturel", or iter any injury or other traumetic event, the Medical Examinar 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 91 hard Son Scockington 19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code 3207 St. 1Kes Wood awn, Ma ane ven 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place, 125/2005 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Voodlawn, Md. Park 4 ☐ Donation 5 ☐ Other (Specify) caine 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Russ Funeral Home, the Balto, Md Joseph L. Russ 2222 W. North Ave. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) leavs Examiner Due to (or es a consequence of): Examiner Attending Physicien: The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 ☑ Unknown 1 ☐ Yee 2 ☐ No ESRU Be Completed by To the Hospital or Attending Physicien: The law require within 24 hours efter death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should to 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 3 DOA 28c. Injury et Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide edicai 29a. Certifier 🖆 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Yeer) 29b. Signature and title of certifier 29c. License number May 20, 2005 37573 30. Name end address of person who completed dause of deeth (Item 23e) (Type, Print) Marin Reisterston MD 21136 Pilaell 25 MD 31. Date filed (Month Pay Year) 32. Registrer's Signature State 2005 4 Registrar

		•	- Stete Unipend Item	Type or Print in loa-f, perin, G8 State of Maryla 23a, 27, 28a-f	6044 <del>6</del> 7	ftilicale all	Death		Reg N			
			Decedent's Name (First, Middle, L.)			initiate or i	<u> </u>	2. Date of Do	eath		3. Time of De	eath
	Physicia /Medic		David Lac	daryl Robins	on			May	9	2005	1305	М
	Examin		4a. Facility Name (If not institution, g				Location of Death	ı	40	County of Death		
2	-		3915 Liberty Hei		s. last birthday	Baltimo	If Under 24 Hrs.	8. Date of Bi	rth	Baltimo 9. Birth	re Gity place (State or F intry)	Foreign
63	Funeral Director		5. Social Security Number 213796–3639	1₹M 2□F 25	Yrs.	Months Days	Hours Min.	(Month, D		2005 Ma		
¥ )	and *		Usual Residence of Decedent  10b. County A	10c.	City, Town or L	ocation					10d. Inside City	Limits
	filed within 72 hours after death with the Maryland Hygiene. uthar than "natural", or Itams 23a or 28a-f show ant, it e Medical Examinat must be notified at		MD N/A	4	City, <b>Explot</b>	more				İ	Yes 2	. □ No
	th the or 28a and til	Directo	3504° Hayward Ave		- /	10f. Zip <b>2721</b>	.5 ,		10g. C	itizen of What Cou	intry?	
	ath wil		UN/			UN				USA		
	ltams	Funerai	<ol> <li>Marital Status</li> <li>Never Married 2  Married</li> </ol>	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerti	pecify Yes or N o Rican, etc.)	0-	14. Race - Amer Black, White	etc.	
036	urs aff	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:			Specify: D	lack	
5-0	72 ho	Completed	15. Decedent's (Specify only highest of		(Give	dent's Usual Occup	turina most of wor	king	16b. H	Kind of Business/I	ndustry	
121	within ane. than	idmo	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	,		Pal	llet Fa	ctory	
d 2	filed Hygie other ant, II	e Co	7th grade 17. Father's Name (First, Middle, La	st)	rac	COLY WOL	18. Mother's Nan		e, Maidei			
Baltimore, Maryland 21215-0036	id 2 should be filed within 72 hours affer the and Mental Hygiene. 27 Is marked other then "natural", or Its traumatic event, the Modical Examine.	To B	Mozell David	Robinson				e Dray				
/ar	permit. Pages 1 and 2 should b Department of Health and Mente Important: If item 27 Is marked any injury or other traumatic enge.		19a. informant's Name/Relationship		19b. Mail	ing Address (Street a	and Number or Ru	ral Route Numb	be <i>r, City</i>	or Town, State, Zi	arvlano	15 d
e,	1 and 2 Health a am 27 Is thar tra		Arline Lee/ Mo  20a. Method of Disposition							ocation - City or T		
йÕ	Pages nent of I int: If its		1 □ Burial 2 □ Cremation 3  '4 □ Donation 5 □ Other (Special	□Removal from State W	cometery, cre estern	osition (Name of matory or other place Star Ce	emetery	4/05		onsvill		
altir	permit. P Departme Importan any injur		21. Signature of Funeral Service Irio	ønsee	2	2. Name and Addres	ss of Facility Cha	atman-	Har	ris Fun	eral H	ome
ä	Per Constitution of the Co		Derny th	ire	5	240 Reis	stersto	wn Rd	Bal	timore,	Md 212	15
			23a. Part1. Enter the iseas , or co shock, or heart failure. List on	ly one cause on each line.					arrest.		Approximate Interval Betwe Onset and De	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Alcohol and		)xycodone)	Intoxica	tion			ois .	
	Examiner			Due to (or as a cons	equence of):							
4		ner	Sequentially list conditions, if any, leading to immediate cause. Enter University	Due to (or as a cons	equence of):							
	kecuted and I-transit	xamin	Cause (Disease or injury that initiated events resulting in death) Last	c	requence of):							
60,	ficate be ex physician a s the burial	ш		Due to (or as a cons	equarica or).							
687	ficate p phys	Physician/Medical		d								
ŏ	leath certifica attending ph I for use as t	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pred 1 Live birth 2 F		□Ectopic pregnancy				23d. Date of deliv		
Э. В	ne deat the atte	sicia	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of		Other (specify)				Month	Day Yea	ar
Division of Vital Records, P.O. Box 68760	a ≥ = ±		9 Unknown  Part II. Other significant conditions	s contributing to death but not	resulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of dea	ath?
ds,	w requires that s been signed t s should be det	d by	, at the enter engineers		<b>3</b>	,		1	Yes 2	No 3□Pro	bably 4 Uni	known
202	w req	Completed						24a. Wa		24b. Were aut	opsy findings av	ailable
Re	The lav te has	mo						auto per 1/KL Yes	opsy formed? 2 \(\sum \) N	death?	ompletion of cau: 2□ No	S9 01
/ital	Physician: The la r this certificate has ral director, page 2	Bec	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only	опе)			
of V	Physic this co	၉	Y Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatie		4   Nursing F	lome 5 Res		6 X Other (Spec	ityScene unk	
on	ding l h. After funer	Certification:	1 Natural 5 Pending 2 Accident investigat	Found: Day Year	Found	Wor	k? Yes 2₽No	200. 56301.00	7 7 10 14 11 11	ary 00001100	UIIK	
Visi	Attendi	ifica	3 Suicide 6 Could no determine	be 300 Place of leiver. A	t home, farm, s		^	28f. Location	(Street a	and 13915° Lu	ibertyffe	ight
Ö	tal or Ars after al Dira	Cert	4 El Homicide	Found: pri	vate dw	elling		Baltimo	ore (	City, Man	ryland	0
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier 1 Certifying (Check only one) 2 X Medical Ex	Physician: To the best of my leminer: On the basis of exam	knowledge, dea ination and/or i	th occurred at the tir nvestigation, in my o	ne, date and place pinion, death occu	e, and due to the irred at the time	e cause(: e, date ar	s) and manner as nd place, and due	stated. to the cause(s)	
	To the within 2 To the complet	Med	29b. Signature and title of certifier	A A		29c. Licens	e number		29d. D	ate signed (Month	, Day, Year)	
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		1	V						- 10	,,, <u>-</u>		
		7	30. Name and address of person wh	no complet use of death (I	tem 23a) (Type		Ctooot	Dc1+4		, Marylar	J 21201	

		•	1 - For State Registrar	State	of Maryla	•	artment <i>rtificate</i>			Mental Hy	gieņe Reg. No. (	15	17432
	Physici	an	1. Decedent's Name (First, Middle		rs 0					2. Date of De Month	. Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution	REGIST		-	4b. City. To	own, or Lo	ocation of Death	May		y of Death	11.00 4
	Examin	ıer	Morris Mo	dical	Cent	er	B	elt	incore			I/A	
	Funeral		5. Social Security Number	6. Sex 1 ፟ M 2 ☐ F		s. last birthday)	If Under 1 Months		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	h	9. Birthp	place (State or Foreign
	Director		217 76 8655	101 M 20 F	47	Yrs.				Feb. 6	, 1958	Mar	yland
	yland iow		10a. State 10b. County		10c. 0	City, Town or Lo	ocation					1	0d. Inside City Limits
	B Mar	ctor	Maryland N/	Α		Baltim	ore						1 🖫 Yes 2 □ No
	vith th	Dire	10e. Street and Number				10f. Zip C				10g. Citizen of		ntry?
	eath v	erai	3816 Fairhay		ecedent Ever in	U.S. 13.	Was Decede	2122		pecify Yes or No	U.S	ce - Americ	can Indian,
ပ္	72 hours after death with the Maryland natural; or Items 23a or 28a-f show dical Examinar must be natified at	by Funeral Directo	1 Never Married 2 Mar	ned Armed	Forces? 2 🔀 No					pecify Yes or No Rican, etc.)		ck, White.	
03	ural', c	d by	3 Widowed 4 Divorced	If Yes, 0 Year or	Dates:		1 ☐ Yes 2		Specify:			か: Whi	
15-(	"natu	iete	(Specify only highe	it's Education st grade complete	d)	(Give	dent's Usual kind of work DO NOT use	done dur	on ring most of wor	king	16b. Kind of E	Business/In	dustry
21215-0036	s within jiene. r than "	Completed	Elementary/Secondary (0-12) 12th	College	(1-4or 5+)		esman	,			Ver	izon	
	be filed ital Hygi d other event, I	BeC	17. Father's Name (First, Middle,			,		1		ne (First, Middle	Maiden Suma	me)	,
yla		Tol		rdon Regi	.ster					Hedge	0" T	74 4 75	. 0. 4.)
Maryland	12 sh ar		19a. Informant's Name/Relations Lori Elam / St				-		a <i>numberornu</i> re Lane	ral Route Numb Apt. C			е, MD 2106
	s 1 and 2 f Health itam 27		20a. Method of Disposition		I	Place of Dispo	osition (Name	of		Date	20c. Location		<u></u>
altimore,	Pages nent of ant: If it.		1 ☐ Burial 2 🕱 Cremation  4 ☐ Donation 5 ☐ Other (S			ayview	_			/2005	Baltin	nore,	Maryland
Balt	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service	Licensee	-		2. Name and			once Fu			•
	00 5 8 0		23a Parti Enter the disease of	complications tha	t caused the de							Mary	1and 21225 Approximate
	Dhysisian		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause or				· · · · · · · · · · · · · · · · · · ·		,			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	Sep8V	equence of):							16 days
	Examiner		Sequentially list conditions.	b	Acute	Respi	ration	1 lys	shess by	Judion	رو		6 days
1/	led Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	d Due t	o (or as a conse	equence of):	1/10	100	rtensi	yudrov .r			> Luear
΄,	be executed sician and burial-transit	Exan	that initiated events resulting in death) Last	c	o (er as a cons	equence of):	9 14	11~	المسا	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			guer
8760,	ate be ex hysician he buria	dicai		d									
9		Med	IF FEMALE:	220 16 1100	outcome of preq								
Вох	eath certific attending p for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 ☐ Fe gnant at time of	etal death 3	□Ectopic pre				1	ate of delivionth	ery Day Year
0	that the de led by the a detached t	hysi	1 Yes 2 No 9 Unknown	9□Un	known								
S, P	es tha igned I be det		Part II. Other significant conditi	ons contributing to	death but not re	esulting in the t	underlying ca	use given	in Part I.		_/		he cause of death?
ord	v requir been si should	sted	MONING OILS	10)						1 🗆	•	3 🗌 Prol	
Records,	has b	Completed by								24a. Was auto	an 24b. osy ormed?	Were auto prior to co death?	ppsy findings available impletion of cause of
Vital I		e Co	25. Was case referred to medica	al					26 Place of Dea	th (Check only	2 No	1 🗆 Yes	2/2 No
fVi	g .v .g	To B	examiner? 1 ☐ Yes 2☐ No	Honnital	Thpatient 2	☐ ER/Outpatie	nt 3 DOA	Other		ome 5 Resi		her (Speci	(y)
n of			27. Manner of Death  1 ☐ Natural 5 ☐ Pendi	119	te of Injury onth, Day Year)	28b. Time of Injury		c. Injury a Work?		28d. Describe	how injury occu	rred	
Division	tend leath tor: the	licat	2 Accident investi		ice of Injury - At	home, farm, st	M reet, factory.		es 2 No			ber or Run	al Route Number,
Div	in Site	Certification:	4  Homicide	bu	lding, etc. (Spe	cify)	, , , , , , , ,			City or To	wn, State)		
	To the Hospital or At within 24 hours after or To tha Funaral Dirac completely filled in by	Medical (		ng Physician: To I Examiner: On the and m									
	To ti withi To th	¥	29b. Signature and title of certific	1000	ATTEN	DING	29c.	License r			29d. Date sign	ed (Month,	Day, Year)
•			rynus	LUU			D-i:		399		May	1111	<b>UU&gt;</b>
	4		30. Name and address of derson	who completed ca	use of death (It	em 23a) (Type ST. PHU	L 81	BI	ALTINE	ors, N	LD		
	Sta		31. Date filed (Month, Day, Year	) 32	. Figistrar's Sig						-		
	Registi	rar	MAY 2	4 2005	Colum	1. 19							

			1 - For State Registrar	State of Maryland		rtment of F		ınd Mei		ene 0 0 5	17433
	Physici /Medic		1. Decedent's Name (First, Middle,	LAST) REYNDLOS					Date of Death Month MAY 2	Day 2003	3. Time of Death
	Examin		4a. Facility Name (If not institution, NINSHWESS A)	SOMAL CENTE		4b. City, Town, o	1255	MMD	1	- /	moret
ŀ	Funeral Director		5. Social Security Number 2 1 6 - 7 4 - 2 3 7 3  Usual Residence of Decedent	7. Age (In yrs. Ia 1	Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, 1 3 - 16 - 1	<sup>(ear)</sup> 9.1 958 M	Birthplace (State or Foreign Country) aryland
	Aaryland I show	o	10a. State 10b. County  Md Balti		, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2ДNo
	r 286-	Director	10e. Street and Number	1101 0	, u	10f. Zip Code			10	g. Citizen of What	
	oth wit 23a o	al D	3506 Baver Ave	núe		2113				USA	
-0036	filed within 72 hours after deeth with the Maryland Hygiene. ther then "naturel", or Itame 23a or 28e-f show int, the MacEcel Examiner must be malified al	by Funeral	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? d 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba	lispanic Orig an, Mexican, Specify:	gin? (Specify , Puerto Ric	y Yes or No- an, etc.)	Black, W	merican Indian, hite, etc. 1 a C k
D-6121	vithin 72 ho ne. hen "natur e Madical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		(Give I lite. L	ent's Usual Occup kind of work done OO NOT use retired SCapin	during most d)	of working		Sb. Kind of Busine	•
and 21	ta do do	Be	17. Father's Name (First, Middle, La Clarence Reyno	ast)	Lanu	Scaping	18. Mother			aiden Sumame)	proyeu
5	should and Men amarke umatic	2	19a. Informant's Name/Relationshi		19b. Mailin	a Address (Street				City or Town, State	a. Zip Code)
<u>Na</u>	d 2 is the street treet		Veronica Reyno								Md 21133
o G	es 1 a of Hea of Heam if item if othe	35	20a. Method of Disposition  A Burial 2 ☐ Cremation 3	CO.	metery, cren	sition (Name of natory or other place	ce)	Date		c. Location - City	
Baltimor	nit. Page: artment or ortent: If i injury or injury or		`4 □Donation 5 □ Other (Spe	ocity)	id Ri		i	-26-0		ikesvil	
a n	permit. Pages 1 an Department of Heal Importent: If Item 2 eny injury or other once.		21. Signature of Funeral Service Ci	censee /							Balto. Co. , Md 21133
			2 I and . Enter the disease, r c slock, or heart failure. List of Immediate Cause (Final				-			12	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	a. ARTERIDSCL Due to (or as a consequent	ence of):	L (FIGLO)	U V 43 C	VLA	( 0)3	this t	
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseque	erica ut).						
8/60,	ate be executed hysician and the burial-transit	icai Exan	that initiated events resulting in death) Last	C. Due to (or as a consequent	ence of):						\$554F 000-00T
٥	certificate Iding phys Ise as the		IS SOLVE	0.							
O. Box	the death certifica y the attending ph ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of decentions	death 3	Ectopic pregnancy Other (specify)	<i>'</i>			23d. Date of d Month	delivery Day Year
cords, P	law requires that the death as been signad by the atter 2 should be detached for u	by	Part II. Other significant condition	s contributing to death but not resul	lting in the un	derlying cause giv	ren in Part I.				to the cause of death?  Probably 4 Unknown
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VItal		o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 🔀	A/Outpatient	t 3□ DOA Oth	0.0		Check only one)	ce 6 ☐Other (S	ngoitu)
	ding Phys h. After this funeral di	H	27. Manner of Death		28b. Time of Injury	28c. Injur				injury occurred	овску
IVISION	Attending or death. ector: After by the funer	catlo	1 Natural 5 ☐ Pending 2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	tion the		M 1	Yes 2□N				
	tel or Ati rs after d al Direct ed in by	Certification;	4 Homicide determin			et, factory, office		281.	City or Town,		Rural Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) Certifying 2 Medical Ex	Physicien: To the best of my know keminer: On the basis of examination and manner stated.	vledge, death on and/or inv	occurred at the tir estigation, in my o	me, date and pinion, death	f place, and h occurred a	due to the cau at the time, dat	se(s) and manner and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	Total mo		ODD.	e number 2497	0	290	I. Date signed (Mo	anth, Day, Year)
	2		30. Name and address of person w	no completed cause of death (Item	23a) (Type, 1	Print)	RAN	1022	STOWN	(MAR)	2005 21133 1LANO
:	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 4	32. Pegistrar's Signatu	k de	and i					

		State of Maryland / Dep State of Maryland / Dep 29b,c,d,30 per Dres		
Physicia		Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year  7.0
/Medica		MICHELLE RUSSEZ	·	5 16 65 100sp
Examine	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth 9. Birthplace (State or Fore
uneral rector		219-74-2978 1 M 2 TF 38 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 2/21/1967 9. Birthplace (State or Fore Country) Maryland
ector		Usual Residence of Decedent		Z/ZI/IJO/ Haryland
Mou		10a. State 10b. County 10c. City, Town or t	ocation	10d. Inside City Lim
or 28a-f show	żo	MD Anne Arundel Annapol	is	1 □ Yes 📆
or 28	j e	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
23a or	Funerai Director	333 Elderwood Court	21401	USA
items mer m	ne	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto F	crify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc.
0 9	by Fr	1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give	1 ☐ Yes 2 No Specify:	Specify: White
natural.		3 Widowed 4 Divorced Year or Dates:	edent's Usual Occupation	16b. Kind of Business/Industry
	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	e kind of work done during most of workin DO NOT use retired)	1g
H H	mc.	Elementary/Secondary (0-12) College (1-4or 5+)	emaker	Own Home
근토	ပိ	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Surname)
D 6	To B	David E. Jorio	Diane	Gordon
is marked aumatic ev	-			I Route Number, City or Town, State, Zip Code)
27 is		Diane Jorio (Mother) 349	Narnia Drive, Sout	ch, Grasonville, MD 21638
E 축		20a. Method of Disposition 20b. Place of Disposition		pate 20c. Location - City or Town, State
y or if		MABurial 2 Cremation 3 Hemoval from State	Israel Cem. 5/18/	/2005 Annapolis, Maryland
continent of the figure of or or or or or or or or or or or or or			22. Name and Address of Facility	
Importa any inju		13- D. Chu-	Hardesty Funeral H	Home, P.A. Annapolis, MD 21401
	-	23a. Part1. Enter the disease, or complications that caused the death. Do not e		
1000		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	Lie Art	Onset and Death
ysician Jedical		disease or condition resulting in death)  a	HEMATICAL	
aminer		MATTER LIE	ALLIE COLLEGE	N 1/ 50AT
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease or injury]	11000 (0001310	MINER
dansit	Examiner	Cause (Disease or injury that initiated events		EMMINER .
		resulting in death) Last Due to (or as a consequence of):	7	PROVED B. CO.
he bu	ical	d		PROVI
as t	ed	IE CENTAL C.	CERTIFIC	
attending for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy	
he att	sicle	in the past 12 months?  1 ☐ Yes 2 ☑ No  4 ☐ Pregnant at time of death 5	Other (specify)	Month Day Year
by the	h	9 Unknown		
e og	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
pluods	ted			1 Yes 2 No 3 Probably 4 Unkno
as be	Completed			24a. Was an autopsy findings availa prior to completion of cause
page 2	NO.			performed?   death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No
	Be (	25. Was crise referred to medical examiner?	26. Place of Death	(Check only one)
dire.	10	1 ☑ Yes 2 ☐ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpati	The second secon	me 5 Residence 6 Other (Specify)
		27. Manner eath 1 vural 5 Pending 28a. Date of Injury 28b. Time Injury Injury 28b. Time Injury	Work?	28d. Describe how injury occurred
or: Af	atle	2 Accident investigation 5 12 05 070		MOTER VEHICLE CULUSU
Direct	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, building, etc. (Specify)	treet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
filled ir		Roadway		Parde MD
within 24 hours  To the Funeral  completely filled	edical	29a. Certifier  (Check only  (		
et	led	one) and manner stated.		
<b>4</b> 6	Ž	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
To the Funeral Director: completely filled in by the		Stefan N. Chock, M.D.	P19429	May 23,2005
Tothe				
To the		30. Name and address of person who completed cause of death (Item 23a) (Typ		
To the			e, Print) ne St., Baltimore,	MD 21201

05-3500 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

IELD Amend Item 5 per FH C849 11/14/05dhb
State of Maryland / Department of Health and Mental Hygiene

1- State Amend Item 2&Unpend Item 23a, 27, 28a-f, per me C844 6-3-05 tas

Registrar Registrar B.K.S BARBARA STANFIELD 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 Year **Physician** 20,\_ MAY BARBARA STANFIELD 1510 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE CITY **Examiner** 604 LUCIA AVENUE NA If Under 1 Year if Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex **Funeral** 1 ☐ M 2 M F 04.01.19 MD51 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event. It a Modical Exeminar must be rediffed at 1 XYes 2 No WD NIA BALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 LUCIA AVENUE USA 604 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 72 (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within h and Mental Hygiene.
7 Is marked other than " College (1-4or 5+) 2 YRS Elementary/Secondary (0-12) HEALTH CARE NURSE 12 TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ANNIE SMITH LLOYD MAITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) WALTER STANFIELD (HUSBAND) 604 LUCIA AVE. BALTO. MD 21229 Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 05.31.05 \* 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST OWINGS MILLS 21. Signature of Fune an Service Licensee VAUGHN C. GREENE FUNERAL SERVICE 5151 BALID NATL PIKE BALID MD 21 23a. Part1. Entel the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he intrailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Methadone and Diazepam Intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 1 Live birth 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown 9 Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed page 2 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6X Other (Specify) AT SCENE 1 X Yes 2 □ No <sup>o</sup>L 28a. Date of Injury **Found**, Day Year) 28b. Time of 28c. Injury at Work? unk 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation Found 2:50 1 Natural 1 ☐ Yes 2 ☐ No 5-20-05 death. 2 Accident Director: / 3 Suicide 6 X Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 604 Lucia Ave. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Baltimore, Mď Found at home within 24 hours at To the Funerel D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical ZX Medicef Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 21, 2005 MAY **OCME** em

Registrar

State

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-ICIA

31. Date filed (Month, Day, Year)

Sperk

111 Penn Street

Baltimore, Maryland 21201

MP

FOLIAK

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State	of Manula	nd / Dono	rtmont of H	ealth and Me	antal Hy	Tions	UU	1

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 5:00 PM M Irma Elizabeth Stewart May 22, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ... 4c. County of Death Examiner 305 Sycamore Road Linthicum Heights Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ■ M 2 F 80 Yrs. Director 219-16-7218 11/14/1924 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Mudical Examiner must be notified at 1 Yes 3 No Anne Arundel Linthicum Heights Direct the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or Items 23a 305 Sycamore Road 21090 United States death Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Ā AS GIVE Specify 3 ₩idowed 4 □ Divorced Year or Dates: "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Federal Government than Elementary/Secondary (0-12) College (1-4or 5+) Clerical 12 if Health and Mental Hyginem 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be George W. Schneider Marie A. McCabe 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paulette Leffler / daughter 230 Stratford Road Brooklyn, NY 11218 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite eny injury or ot once. 1 Burial 2 Cremation 3 Removal from State May 24 \* 4 □ Donation 5 □ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2005 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility M00986 PL Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition GALL BLADDER **Physician** MOS /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Box 68760 the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) P.O. 1 Yes 2 No detached 9 Unknown 9 Unknown certificate has been signed by irector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 GNatural 5 Pending investigation М 1 ☐ Yes 2 ☐ No death 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of co 29c. License number 29d. Date signed (Month, Day, Year) 23/05 CLEN BURNIE odress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 2168 M.0 SUITE106 1406 S. CRAIN 4 2005 32. Registrar's Signatur State

DHMH 17 Rev 1/2001

Registrar

			4 177.	partment of Health and Mertificate of Death		ne 005 17437
	Physic		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
	/Medi Exami		Rehana 4a. Eacility Name (If not institution, give street and number) Sount Agnes Hospital	Shaikh  4b. City, Town, or Location of Death  Baltimore	May	4c. County of Death
	Funeral Director		5. Social Security Number  6. Sex 1 M XXF 7. Age (In yrs. last birthday Yrs.  Usual Residence of Decedent	/ If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, You 10 01	9. Birthplace (State or Foreign Country) 58 India
	death with the Maryland ms 23e or 28a-f show rgount be notified ≇t	Director	10a. State 10b. County 10c. City, Town or to 10m 10c. City, Town or to 10c. City, Town o	ville		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
		Funerai Dire	10e. Street and Number           6119 Burnt Oak Road           11. Marital Status         12. Was Decedent Ever in U.S. Armed Forces?         13.	10f. Zip Code  21228  . Was Decedent of Hispanic Origin? (Spell Yes, specify Cuban, Mexican, Puerto		Citizen of What Country?  India  14. Race - American Indian,
	1215-0036 within 72 hours after ene. then "naturel; or ite he Medical Examins	þ	1 □ Never Married XX Married 1 □ Yes ZX No If Yes, Give Year or Dates:	1 Yes X No Specify:  edent's Usual Occupation		Black, White, etc.  Specify: Asian  b. Kind of Business/Industry
	Maryland 21215-0036 d 2 should be filed within 72 hours aft the and Mental Hygiene. 27 is marked other then "naturel", or traumatic event, the Medical Exam.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  12th grade  College (1-4or 5+)  L	e kind of work done during most of working DO NOT use retired)  aborer	ng	Bowles Corp
	Maryland 2121( 12 should be filed within 1 12 and Menial Hygiene. 7 is marked other then "riceumatic event, Ine Mag	To Be	17. Father's Name (First, Middle, Last)  Ismaiel Shaikh  19a. Informant's Name/Relationship (Type, Print)  19b. Mail	18. Mother's Name	(First, Middle, Mai	Shaikh
	Baltimore, Mi permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition 3 Removal from State		late 200	nsville, Md 21228 : Location - City or Town, State andallstown, Md
	Balt permit. Depart Import any inj		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Iarch F/H West 1300 Wabash Ave,	Baltim	ore, Md 21215
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a	scephalopath	<del></del>	Onset and Death Unknown
lana	icate be executed physician and it the burial-transit	dical Examiner	fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):	emia		
h, Rei	, P.O. Box 687 that the death certificate of by the attending physical detached for use as the	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Jaikh	<b>လ</b> 8 5 8	by	Part II. Other significant conditions contributing to death but not resulting in the temperature of the significant conditions contributing to death but not resulting in the temperature of the significant conditions contributing to death but not resulting in the temperature of the significant conditions contributing to death but not resulting in the temperature of the significant conditions contributing to death but not resulting in the temperature of the significant conditions contributing to death but not resulting in the temperature of the significant conditions contributing to death but not resulting in the temperature of the significant conditions contributing to death but not resulting in the temperature of the significant conditions contributing to death but not resulting in the temperature of the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting to the significant conditions contributed by th	Indertying cause given in Part I.	23e. Did tobace	co use contribute to the cause of death?  2 No 3 Probably 4 Unknown
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	on of ting Phys	on; To B	25. Was case referred to medical examiner?  1	of 28c. Injury at Work?		e 6 Other (Specify)
	Division of ei or Attending Physics as after death.  In Director: After this din by the funeral did in by the	Certificati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		8f. Location (Street City or Town, St	and Number or Rural Route Number, tate)
	Division To the Hospitel or Attending within 24 hours after death. To the Funerel Director After completely filled in by the fune	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal 2 Medicel Exeminer: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurre	nd due to the cause od at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To with To t	M	29b. Signature and title of certifier  Khairvninisa Masood	$\mathcal{D}$ 62950	29d. MC	Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Khairun misa Mascod St. Agii 31. Date filed (Month, Day, Year), 33 Registrar's Signature	nes Hospital,	Baltim	ore, Maryland.
	Sta Regist		31. Date filed (Month, Day, Year) MAY 2 4 2005	est.		U

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death John H. Schramm 6:37 A M May 2005 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 30 South Ritters Lane Owings Mills Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Nov. 28, 1 Birthplace (State or Foreign Country) Days Months Hours Min 17€ M 2 □ F 51 217-60-2308 1953 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Owings Mills Baltimore Maryland 10e. Street and Number 10g. Citizen of What Country? 30 South Ritters Lane 21117 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 197
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1971 1974 1 Never Married Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Journeyman Plumber Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Schramm Dolores Kilroy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dana Schramm, Wife 30 South Ritters Lane Owings Mills, Maryland 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State ' 4 Donation 5 Dother (Specify) Metro Crematory Inc. 05/23/05 Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor <sup>22. Name and Address of Facility</sup>
Cremation Society Of Maryland Inc.
299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final espue -61 5043 disease or condition resulting in death) Due to (or as a consequence of) a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐ Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Tyes 2 No 2 Accident

The law requires that the death certificate be executed for use as the burial-transit Division of Vital Records, P.O. Box 68760, has this certificate or Attending Physicien: After 1 death. s after death

been signed by the attending physician should be detached for use as the burial page 2 the funeral director, completely filled in by within 24 hours a To the Funeret I

**Physician** 

/Medical

Examiner

Director

Completed by Funeral

Be

2

Examiner

Physician/Medical

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Completed

Be

Medical Certification: To

3 🗌 Suicide

29a. Certifier

4 Homicide

**Funeral** 

Director

and Mental Hygiene.
Is marked other than "natural", or itams 23s or 28s-f show
reumatic event, the Medical Exercitation in the notified at

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other

ö permit. Page Department of Important: if any injury or

**Physician** 

/Medical

**Examiner** 

Pages 1 and 2 should be fill ment of Health and Mental Hisnt: If item 27 is marked other

the Maryland

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

0

State

Registrar

6 ☐ Could not be

determined

and manner stated

29c. License number

1 \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Jonathan 31. Date filed (Month, Day, Year)

29b. Signature and title of certify

32. Registrar's Signature MAY 2 4 2005

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State

of Maryland / Department of Health and Mental Hygi-	ene 🛚	)5	7	+ 3	1
Certificate of Death					

		1 - For Stata Registrar		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Cert	ificate of L	Death		Reg. No.		1 7 7	
Dhysis		1. Decedent's Name (First, Middle, Las	it)					2. Date of De.		Vear	3. Time o	f Death
Physic /Medi		Norman H. Sai	lors					May	19	2005	9:26	Рм
Exami	ner	4a. Facility Name (If not institution, give				4b. Cily, Town, or	Location of Death		4c.	County of Death		
		St. Agnes Hospit  5. Social Security Number 6. Secu		In yrs. last birti	h day)	Balti If Under 1 Year	More If Under 24 Hrs.	O Data of Bird		N/A	-la (O)	
Funeral Director			ØM 2□F		birthday) If Under 1 Year If Under 24 Hrs. Nonths Days Hours Min. Oct. 26, 1942 9. Birthplace (State (Month, Day, Year) Oct. 26, 1942 Mary Land							or Foreign
land bw		10a. State 10b. County	1	0c. City, Town	or Loc	ation					Od. Inside C	ity Limits
Marylan -f show iled at	ţ	Maryland N/A		F	3alt	imore					1X Yes	2 🗌 No
h the M r 28a-f	Director	10e. Street and Number				10f. Zip Code			10g. Citi	izen of What Cou	ntry?	
h with		20 North Wolfe	Street			2123	31			USA		
er death w Items 23a ner musi c	Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. W	as Decedent of Hi	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No	-	14. Race - Americ Black, White,		
be filed within 72 hours after death with the Maryland tal hygiene. Id hygiene. Id other than "netural", or liems 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎇 Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		)	□Yes 2⊠No	Specify:	7.1.0_2.1, 0.0.1,		Specify: Whi		
72 h	ete	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a.	Decede (Give k	nt's Usual Occupa	ation during most of work ')	king	16b. Ki	ind of Business/In	dustry	
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filed Hygie ther	e Co	17. Father's Name (First, Middle, Last)				Darcomari	18. Mother's Nam	e (First, Middle,				
d be ental ked o	To Be	Madison Sailors						thy A. S				
should Mind Mind Mind Mind	F	19a. Informant's Name/Relationship (7	Type, Print)	19b.	Mailing	Address (Street a	and Number or Rui				Code)	
Tand 2 should Health and Men Men Men Men the arket the treumatic		Roxane Hooper / E	riancee	20	No	rth Wolf	e Street	Baltimo	ore,	Marylan	d 2123	31
of He of He rothe		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐		20b. Place of cemeters	Dispos	tion (Name of atory or other place	e)	Date	20c. Lo	cation - City or To	own, State	
permit. Pages 1 and 2 should permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 is marke enry injury or other treumatic.		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	2)	Metro		matory I		23/05		timore,	Mary1a	ind
permit. Departr Importe eny inji		Thomas Gregor	region		129	9_Freder	s of Facility Society ick Road	Baltimo	ore,	Inc. Marylan	d 2122	.8
Physician /Medical Examiner		23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Hyrarta	Consequence of	of.		g, such as cardiac Onotice (d			Disase	Approximat Interval Bet Onset and	ween
ritificate be executed ng physician and as the burial-transit	Medical Examiner	if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or as a dot)  Due to (or as a dot)									
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quires that n signed build be deta	by	Part II. Other significant conditions o	ontributing to death but	not resulting in	the und	derlying cause give	en in Part I.		obacco u Yes 2]	se contribute to the	ne cause of c	
ysicien: The law require rs certificate has been si director, page 2 should to	Completed									24b. Were auto prior to co death?		available ause of
icien: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:	37		04	26. Place of Dea					
, £ = a	2	1 A Yes 2 No 27. Manner of Death	1 ☐ Inpatient	2 ER/Out		3□ DOA Othe	4   Nursing n	ome 5 Resident		6 □Other (Specif	y)	
ending sath. or: After	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day )		ijury	Work	Yes 2□No	200. Describe i	iow injui	y occurred		
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director,	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	/ - At home, far (Specify)	m, stre	et, factory, office		28f. Location (S City or Tov		d Number or Rura )	I Route Num	iber,
ne Hosp n 24 hou he Funei bletely fil	Medical	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ XMedical Exan	ysician: To the best of niner: On the basis of e and manner state	xamination and	death Vor inve	occurred at the time stigation, in my or	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) date and	and manner as s I place, and due to	tated. the cause(s	s)
To t withi To tl	Σ	29b. Signature and tille of certifier	///			29c. License	number			e signed (Month,		
		WILL	X			OCM	-		May	20, 200	5	
N		30. Name and address of person who	completed cause of dea	th (Item 23a) (	Туре, Р		enn Stree	t Balti	more	Marvlan	d 2120	)1
St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 2 4 2005	32. Registrar		ask			20101			<u></u>	

State of Maryland / Department of Health and Mental Hygiene U [] 5 For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Lawrence Albert Schultz, Sr. Year 7:30 A.M May 19. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise Assisted Living Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 13 M 2□ F 216-01-1259 Director Yrs. 84 July 21, 1920 Maryland Usual Residence of Decedent Maryland 10a, State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other traumatic event. I've Mudical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No Maryland Howard Columbia the 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? items 23a or 6400 Freetown Road 21045 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [XYes 2 □ No If Yes, Give Year or Dates: WWII 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify: 3 XWidowed 4 ☐ Divorced "natural" 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any injury or other traumatic event, ITE Magnes, and once. Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Accountant</u> U.S. Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Sonnenleiter 2 Louise F. Schultz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret M. Bertulis Daughter 4919 Clearwater Drive; Ellicott City, MD 21043 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State New Cathedral Cemetery 5/23/05 Baltimore, Maryland <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service Licenses 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final heard **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequent Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician for use as the burial Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed certificate has t irector, page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 1 ☐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) ssisted Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 7 ther (Specify 28a. Date of Injury (Month, Day Year) After th funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct or mpletely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie (Check only 29b. Signature and title of continer 30. Name and address of person who completed cause of death (Item 33a) (Type, Print) 31. Date filed (Month, Pay Year) 32. Resistrar's Signature State Registrar

		Please Type or Print in Blace State of Maryland / 1  1- State Registre FINE C844	Department of	Health and M	Mental Hy	_		
Physici /Medio	al	1. Decedent's Name (First, Middle, Last)  Theodore K. Snovell, Jr.			2. Date of De Month May	Day Year 200.	5 7:34P <sup>M</sup>	
Examin	er	4a. Facility Name (If not institution, give street and number)  9417 Ashlyn Circle  5. Social Security Number 6. Sex 7. Age (In yrs. last bi	Owing	or Location of Death SS Mills If Under 24 Hrs.			Baltimore	
Funeral Director		5. Social Security Number 215-18-6197  Usual Residence of Decedent  6. Sex 1 M 2 F 7. Age (In yrs. last bited) 81	Yrs. Months Days		8. Date of Birt (Month, Da Aug. 2	y, Year) (	irthplace (State or Foreig Country) ryland	
Maryland a-f show	tor	10a. State 10b. County 10c. City, Tow	on or Location				10d. Inside City Limits 1 ☐ Yes 25☐ No	
h with the 23a or 28	ai Director	10e. Street and Number 9417 Ashlyn Circle	10f. Zip Code	1117		10g. Citizen of What (		
ine, intellylating Z.I.Z.I.O.O.O.O. s. 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatte event, the Medical Examination must be notified at	Completed by Funeral	11. Marital Status  1 □ Never Married 2점 Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☑ Yes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cul		pecify Yes or No Rican, etc.)	Specify		
within 72 hours all giene. er than "natural", or tre Medical Exami	pieted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	upation e during most of work red)	king	16b. Kind of Busines	ss/Industry	
Mal yldild AIA II. 2. Should be filed within In and Mental Hygiene. Tis marked other than "raumatic event, I'm Me.	То Ве Соп		ivil Enginee		Enginee Maiden Surname) rman	ring		
ie, indi yldi id 1 and 2 should be file Health and Mental Hy Iem 27 is marked oth other traumatic event	-	T. Starr Snovell (Wife) 94	b. Mailing Address (Street 17 Ashlyn (	Circle Owi	ngs Mil	ls, Maryla	nd 21117	
t. Page rtment c rtant: If		I - Odnar 2 K Oremation 3 - Hemoval non State	of Disposition (Name of ery, crematory or other plane peake Cremat 22. Name and Addi	tory 5-24	Date 1-2005	20c. Location - City of Beltsville	n Town, State	
Dermi Depa Impo any ii		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	Witzke Fur 1630 Edmor	neral Home ndson Ave.	Catons	onsville, ville, MD	Inc. 21228 Approximate Interval Between	
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a	celllun				Onset and Death	
ificate be executed g physician and as the burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate course. Enter thickness or injury that initiated events resulting in death) Last  b. Due to (or as a consequence course, consequence)  c. Due to (or as a consequence)	-17					
Physician: The law requires that the death certificate in this certificate has been signed by the attending physical director, page 2 should be detached for use as the tall of the certificate has been signed by the attending physical director, page 2 should be detached for use as the tall director.	Physician/Medi	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death	n 3 □Ectopic pregnand 5 □ Other (specify)	су		23d. Date of d Month	elivery Day Year	
w requires that been signed I should be det	ed by P	Part II. Other significant conditions contributing to death but not resulting in hody Kins lymphom	, , ,	oven in Part I.	23e. Did to	obacco use contribute Yes 2 No 3 7	to the cause of death?  Probably 4 □Unknow	
Physician: The law requires the law requires this certificate has been signeral director, page 2 should be.	Completed by	7			24a. Was autop perfor 1 \( \text{Yes} \)	osy prior to rmed? death?	autopsy findings available completion of cause of s 2 No	
aiclan: Th certificate irector, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 FR/Oi		26. Place of Deat	1/2/2/2			
	$\vdash$	27. Manner of Death 28a. Date of Injury 28b.	Time of 28c. Injury	4 Li Nursing Ho		dence 6 Other (Sp now injury occurred	ecify)	
Division:  To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	Э	28f. Location (S City or Tow	Street and Number or F vn, State)	Rural Route Number,	
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To t With To t	Σ	29b. Signature and title of certifier		redmun ear		29d. Date signed (Mor		
P			(Type, Print)			e Mp2	,	
Sta Registr		31. Date (illed (Month, Day, Year) 32. Registrar's Signature MAY 2 4 2005	1-4-			<del>-</del>	,	

		4	1 - For State Registrar	State of M	arylan				ealth a			giene Reg. No.	05	17442	
			1. Decedent's Name (First, Middle, La	ast)							2. Date of De	ath		3. Time of Death	-
	Physici /Medic		Virginia Sai	MOSON							May	Day   9	2005	3:00 aM	
	Examin		4a. Facility Name (If not institution, gir	ve street and number)			4b. City,	Town, or	Location of	of Death	,,	4c. Cou	unty of Death		_
		•	University of Mar	yland Med	lical	(enter	Ва		noce			1	114		
	Funeral		5. Social Security Number 6.	Sex 7. Ag		last birthday)	If Under	1 Year	If Under		B. Date of Bir	th Year	9. Birthp	lace (State or Foreign	-
	Director		387-20-7652	1□M 2⊠F	79	Yrs.	Months	Days	Hours	Min.	(Month, Da ec. 2,	1925	Wisco		
	P.		Usual Residence of Decedent												_
	show	li-sa	10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits	
	Ba-f	cto	Maryland Howard		E]	llicott	Cit	у						1 ☐ Yes 2 🖾 No	
	or 2	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Cour	ntry?	
	23a		3337 North Ch	atham Road			2	1042				U.S	5.A.		
	tams	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		.S. 13. V	Vas Dece	dent of Hi	spanic Ori	gin? (Spec	ify Yes or No ican, etc.)		Race - Americ Black, White,		
36	or l	by F	1 Never Married 2 Married	1 ☐ Yes 2 ☑ If Yes, Give	No	1	Yes	2 No	Specify:				ecify:		
8	filed within 72 hours atter death with the Maryland Hygiene. ther then "natural", or Itams 23a or 28a-f show int, the Medical Examination and the motified at		3 Widowed 4 Divorced	Year or Dates:		10.0							Wh	ite	_
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2	filed Hygi ther int,	e C	17. Father's Name (First, Middle, Las			Nu	IISE		18. Mothe	er's Name	First Middle	, Maiden Sur	spital		_
aŭ	d be ontal sed o	<b>8</b>	Francis Tennis	*							rvice	, maidon Can			
Maryland 21215-0036	houl d Me mark	J.	19a. Informant's Name/Relationship	(Type Print)		19h Mailin	n Address	(Street s				or City or To	wn, State, Zip	Codel	_
Ma	id 2 s ith ar 27 is trau		Tillman Sampson	(Husband)										D 21042	
é,	l an Heal Hern Hern		20a. Method of Disposition	(Habbana)	20b. F	lace of Dispos	sition (Nai	ne of	1	Da			on - City or To		_
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itams 23a or 28a-1 show any injury or other traumatic evant, the Medical Expression and two milled at ance.		1 Burial 2 Cremation 3		0	emetery, cren	natory or o	ther place	1	- 01					
臣	artme artme ortan injury		*4 □Donation 5 □ Other (Special Signature of Fune 3 Service Lice		Bal	to/Was							1, Mar	yland	_
Ba	Depa Impo any ir		MA	1100							, Inc.				
			23a. Part1. Enter the disease, or con	nolications that cause	d the deat								MD 210	Approximate	_
			shock, or heart failure. List only Immediate Cause (Final	one cause on each I	ne.			.c o. ay,	9, 00011 00	our dido or	respiratory a	Troot,		Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)			erbat	100								
	Examiner		1	Due to (or as	a conseq	uence of):									
100		- G	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseq	uence of):									_
V	Insit	ulu u	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a Afib	TR	VR									
	al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as											-
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		∂ त											
89	ficate pphy s the			u											_
Box	nding use a	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d.	Date of delive	erv	
ă	d for	cla	in the past 12 months? 1 \( \sum \) Yes 2 \( \sum \) No	1□Live birth 4□Pregnant a			Ectopic pi   Other (sp						Month	Day Year	
P.0.	that the death certific ed by the attending p detached for use as	hys	9 □ Unknown	9□ Unknown											
	res that signed to be det	Completed by Physiclan/Me	Part II. Other significant conditions	contributing to death t	out not res	ulting in the ur	nderlying o	ause give	n in Part I.		23e. Did t	obacco use o	contribute to th	e cause of death?	
ğ	w require been sig should b	a p	MRSA bacteren	1 d							10	Yes 2 🕱 N	o 3 🗆 Prob	ably 4 Unknown	
000	s bee	olet									24a. Was	an 24	b. Were auto	psy findings available	_
æ	The lav te has age 2	mo										psy ormed?	prior to cor death?	npletion of cause of	
Division of Vital Records,		a	25. Was case referred to medical						26 Place	of Death	1 Yes	2 No	1 🗌 Yes	2L No	_
>	Physician: this certific ral director.	To B	examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1 XInpati	ent 2 🗆	ER/Outpatien	t 3□ D0	Othe	Ar-				Other (Specify	0	_
0	g Phys er this eral di	n: T	27. Manner of Death	28a. Date of Inju	ıry	28b. Time of		28c. Injury Work				how injury oc		7	_
0	ndin ath: r: Aft	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		iy rear)	Injury	М		res 2 🔲	No					
Vis	ar de sacto	tifle	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		ury - At ho	ome, farm, stre	et, factor	y, office		28	If Location (S City or Tox	Street and Nu	ımber or Rura	l Route Number,	-
Ö	s after salter s	Certification:		Dunding, e	ic. (Opecii	<b>y</b> /					City of 101	WII, State)			
	To the Hospital or Attending Phys within 24 hours attendeath. To the Funaral Diractor: After this completely filled in by the funeral directors.	edical	29a. Certifier 1 Certifying P	hysician: To the best miner: On the basis of	of my kno	wiedge, death	occurred	at the tim	e, date an	d place, ar	d due to the	cause(s) and	manner as st	ated.	
	the H in 24 the F iplete	edi	one)	and manner st	ated.	morr arroy or irry	estigation	, in my op	nion, dea	in occurred	at the time,	date and plac	ce, and due to	ine cause(s)	
	With To	Σ	29b. Signature and title of certifier	Haz K	1	-Np		c. License					gned (Month,	Day, Year)	
)			Stacy Kenne	dy MD			A	417	6435	K 158	(१	5/19	105		
	1 -		30. Name and address of person who	4											_
	le		Stary Kenner	14 MO 2.	2 S.	Gree	ne:	stre	et,	Balt	imore,	102	-1201		
#	Sta Registr		31. Date filed (Mon MAY Year)	2005 32 Registr	rar's Signa	ture -	all i								
	region	या		1	~	- AU -	-								

DionneSanders **JET** Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05-03414 1 - For State Registrar Certificate of Death Reg. No Unknown 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** DIONNE O. SANDERS May 2005 3:06 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Johns Hopkins Hospital Baltimore
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7-13-1979 5. Social Security Number 6. Sex 1∆ M 2 ☐ F 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months Days Hours 215-96-7854 MARYLAND Yrs. 25 Director Usual Residence of Decedent with the Maryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or Items 23e or 28a-f show the Wedical Examinar must be notified at 1 Tyes 2 No N/ABALTIMORE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1628 KINGSWAY RD. 21218 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: BLACK Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) LABORER CONSTRUCTION -11--0-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil tment of Health and Mental H tent: If item 27 le marked otl ODELL SANDERS REATHA BROWN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 le any injury or other treu once. REATHA SANDERS (MOTHER) 1628 KINGSWAY RD. BALTIMORE, MARYLAND 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Commation 3 Removal from State
4 Donation 5 Other (Specify) MT. ZION CEMETERY 5-23-2005 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licersee JONATHAN D. HIBNER Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 oner the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, to heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Questo for as a consequence of): Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical as attending F IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ZNo 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? 2 🗆 No Yes 2 🗆 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 2 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Subject shot 28b. Time of 27. Manner of Death After t Certification: or Attending 5 Pending investigation 1 Natural 238™ death. 1 ☐ Yes 2 👿 No after death 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, 600 lives Town State North Cost Venus 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Avenue on the To the Hospitel within 24 hours a To the Funeral E ground 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State

30. Name and address of person who completed cause of

CONICA

4

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001 ath (Item 23a) (Type, Print)

2005 Agentiar's Signature

OCME

May 17 2005

⊃ 111 Penn Street Baltimore Maryland 21201

				State of M			Health and I	•	-	non 1 mm 1 1 1		
			1 - For State Registrar	Otate of W		ertificate of		_	Reg. No.	5 /444		
			Decedent's Name (First, Middle, L.	ast)				2. Date of De	ath	3. Time of Death		
	Physici /Medi		IRVIN			SILBER	RMAN	Month MAY	21 2	005 4:25 A M		
Y	Examir		4a. Facility Name (If not institution, g			4b. City, Town	, or Location of Death	1	4c. County			
			JEWISH CONVALES			BALTI				BALTIMORE		
, Sc.	Funeral Director		5. Social Security Number 6. 214-12-1107	Sex 7. Ag	ge (In yrs. last birthd 83 Yrs	Months Day		8. Date of Bir (Month, Da JUL . 7	1921	Birthplace (State or Foreign Country)     MD		
	and *		Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits		
	Mary!	ō		LTIMORE		LTIMORE				1 ☐ Yes 2 ☑ No		
	r 28a	Director	10e. Street and Number	ETTTOKE		10f. Zip Code	1		10g. Citizen of W			
	th with	a D	7920 SCOTTS LE	VEL ROAD			21208			USA		
	ems ems	by Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No	- 14. Race	e - American Indian, k, White, etc.		
36	s afte	γFι	1 ☐ Never Married 2 ☐ Married 3 🗖 Widowed 4 ☐ Divorced	1 □ Yes 2 💢	No	1 ☐ Yes 2 🕅 N			Specify			
Ö	within 72 hours after death with the Maryland one. than "natural", or items 23e or 28e-f show the Medical Examinar most be neithed at	ed b	15. Decedent's	Year or Dates:		ecedent's Usual Occ			16b. Kind of Bu			
7.	nin 72 n "ne	plet	(Specify only highest g		(G	live kind of work don e. DO NOT use reti	e during most of wor	king	100. Kind of du	siness industry		
21,	od with	Completed	Clambridary/Gecordary (0-12)	2	PROP	RIETOR			VENDIN	3		
pu	be filed tal Hygid d other event, I	Be	17. Father's Name (First, Middle, Las	<i>t</i> )			18. Mother's Nam		Maiden Sumam	θ)		
<u>3</u>	should ind Men in marke	2	DAVID		SILBER		(UNKNO)			(UNKNOWN)		
Mar	d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship STUART SILBERM				et and Number or Ru ΔKF NDIVF			State, Zip Code) , MD 21117		
ē,	ges 1 and 2 should be filed within 72 hours atter death with the Marylan tt of Heath and Mental Hygiene. If Item 27 is marked other than "naturar", or Items 23s or 28s-f show or other traumatic event, If a Medical Eraphra must be notified at		20a. Method of Disposition	AN / 30N	20b. Place of Di	sposition (Name of		Date		City or Town, State		
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heat Important: If Item 2 eny injury or other 2002.		1 A Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec			crematory or other p	PARK 5/23	3/2005	RANI	DALLSTOWN, MD		
alti	permit. I Departm Importa eny inju		21. Signature of Funeral Service Lice		JETH EL	22. Name and Add				ROS., INC.		
m	Depa Impo eny it		Jul (Nar)	sevi			STERSTOWN	ROAD -	PIKESVII	LLE, MD 21208		
			23a. Parvi. Enter the disease for conshock, or heart failure. List only	plications that caused y one cause on each li	the death. Do not ne.	enter the mode of dy	ying, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between		
<b>)</b>	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Cardie	thromb	stic eve	nt			Onset and Death		
	/Medical Examiner		1 double		a consequence of):							
	A	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):							
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x 68	The law requires that the death certificate ate has been signed by the attending phy page 2 should be detached for use as the	by Physician/Med	IF FEMALE:	23c. If yes, outcome	of programmy							
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Division of Vital Records,	w require been sig should b	edt						101	res 2□No	3□ Probably 4 Donknown		
ecc	law re as be 2 sho	Completed						24a. Was	an 246. W	Vere autopsy findings available rior to completion of cause of		
<u> </u>	The ate h	Con					/	perfo	rmed?	eath? □Yes 2□No		
Vita	sician: The law certificate has b irector, page 2 s	Be	25. Was case referred to predical examiner?	Hospital:			26. Place of Dea					
of	Phys this ral dir	. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatie	ent 2 ER/Outpa	tient 3 DOA			dence 6 Othe			
on	nding th. : Alte	ıtlon	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigate	(Month, Da	y Year) Inju	y W	ork? ☐ Yes 2 ☐ No	Zod. Doschoe i	iow injury occurre	ld.		
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Ö	tal or rs afte al Dir ed in	Certification:	4 LI TOMIEDO	building, et	с. (эрөспу)			City or Tox	vn, State)			
	Hospi 4 hou Funer ely fill	icai	(Uneck only 2 Medical Exe	hysician: To the best eminer: On the basis o	f examination and/o	eath occurred at the	time, date and place,	and due to the	cause(s) and mar	ner as stated.		
	To the Hospital or Attanding Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	one)  29b. Signature and title of pertifier	and manner sta	ated.		rse number			(Month, Day, Year)		
	T × 0		The All -	chem.D.			00057 40			2 1/05		
	M		30. Name and address of person who		leath (Item 23a) (Tvi	oe. Print)						
	(1)		N.S. Rajapakseno	· 25 Ma	inst, suil	e 200, R	eisterston	nn, n	1D Z11	56.		
45.4	Sta		31. Date filed (Month, Day, Year)		ar's Signature							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** May 19, 2005 6:00 a Joseph Timperio /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Mariner Health of Silver Spring Silver Spring Montgomery 8. Date of Birth (Month, Day Year) Oct. 25, 1925 9. Birthplace (State or Foreign Country)
Cleveland, OH 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** Days Hours **X**X M 2□ F 79 Director 188-16-2354 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner roust be notified at 1√2 Yes 2 No Director Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 20902 United States 901 Arcola Avenue by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. within 72 hours after 1 ☑ Yes 2 □ No 1941 — If Yes, Give Year or Dates: 1945 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No white 3 Widowed 4 Divorced "netural', 1945 15. Decedent's Education (Specify only highest grade completed) Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Food Services and Mental Hygiene. Elementary/Secondary (0-12) Hotel Manager - Food 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 9008: Be Lucy Decrescinzo Nicholas John Timperio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2090219a. Informant's Name/Relationship (Type, Print) 1135 University Blvd., #412, Silver Spring, MD Carol Timperio, wife Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 5/21/05 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licenses MO0382 Rapp Funeral and Cremation Services 933 Gist Steple D Lohmann Avenue, Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final ACOTE INFARCTION MINUTE MYOCARDIAL **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical as the the attending IF FEMALE: esn 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 I ive birth 2 Fetal death 3 Ectopic pregnancy Year signed by the atte 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ASPIRA TION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the autopsy performed 2□ No 2 No 1 Yes 1 ☐ Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ ₩0 Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Fursing Home 5 Residence 6 Other (Specify) 2 within 24 hours after community to the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 009874 May 20, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3720 FARRAGUT AVE KENSINGTON, MD 32 Registrar's Signature 31. Date filed (Mont State Registrar

		1	For State Registrer	S	tate of	f Maryla	and / Dep <i>Ce</i>	artmen <i>rtificat</i>					Reg. No.	005	17446
	<b>D</b> 1 -1-1-		1. Decedent's Name (First, Middle, I				1					<ol><li>Date of Dea Month</li></ol>	ath Day	Year	3. Time of Death
	Physicia /Medic			1V-8	line		Toryl					May	23		
	Examin	er	4a. Facility Name (If not institution, g			nber)		4b. City,	Town, or	Location	of Death	,		County of De	
			Augsburg Luthera			7 4 //-	um. In at hirth day	) If Under		Wynn If Under		8. Date of Birl		ltimor	
П	Funeral		,	Sex 1 ☐ M	2 <b>X</b> F	7. Age (In ) 9 0	rs. last birthday Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)		rthplace (State or Foreign Country)
	Director	-	213-14-0658 Usual Residence of Decedent			- 50		J				12/01/	1914	MD	
	land ow	-	10a. State 10b. County			10c.	City, Town or L	ocation							10d. Inside City Limits
	Mary 1 sh	ţ	MD			В	altimor	e							Yes 2 □ No
	r 28e	0	10e. Street and Number					10f. Zip	Code				10g. Citiz	zen of What (	Country?
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	deatl	Funeral	11. Marital Status		Was Dece	dent Ever i	n U.S. 13	Was Dece	dent of H	ispanic Or in, Mexical	igin? (Spe	ecify Yes or No Rican, etc.)	- 1	14. Race - An Black, Wh	nerican Indian, site, etc.
9	after or Ite	臣	1 ☐ Never Married 2 ☐ Married		1 ☐ Yes If Yes, Giv	2 No		1 🗆 Yes		Specify:			1	Specify:	
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21215-0036	72 h "natu	Completed by	15. Decedent's (Specify onfy highest	Educati grade co	ion o <i>mpleted)</i>		(Giv	edent's Usua e kind of wo DO NOT u	rk done d	during mos	it of work	ing		torial	
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7	filed within 72 hours after death with the Maryland Hygiene. Ather then "natural", or Items 23a or 28e-f show ant, Ite Modeal Examiner must be notified at	e Co	17. Father's Name (First, Middle, La	st)			Done	SCIC		18. Moth	er's Name	e (First, Middle	Maiden	Sumame)	
anc	od ol	m	Samuel White							Mary	So	llers			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural; or Items 23a or 28e-1 show amy injury or other traumatic event, Ite Marical Examiner must be notified at any injury or other traumatic event, Ite Marical Examiner must be notified at angre.	2	19a. Informant's Name/Relationship	(Type,	Print)		19b. Mai	ling Address	(Street	and Numb	er or Run	al Route Numb	er, City or	Town, State	Zip Code)
<b>∑</b>	nd 2 stranger trans		William Taylor S	·/s	on		1131	Haub	ert	Stree	t Ba	ltimore	, MD	21230	)
ā,	Hea Hea tem		20a. Method of Disposition			20	b. Place of Disp cemetery, cr	osition (Na	me of other place	(e)		Date	20c. Lo	cation - City	or Town, State
9	Pages nent of nnt: If It ury or o		1 ☐ Burial 2 ② Cremation 3  4 ☐ Donation 5 ☐ Other (Spe		noval from	State	hesapea				nc.	May 24   2005	Belt	sville	, Maryland
Baltimore,	artme orter injur	Í	21. Signature of Funeral Service Li	-	-		180	22. Name ar	nd Addre	ss of Facil	ity				
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687	y s	dical		d											
9 ×	death certificat e attending phy d for use as th	Physician/Med	IF FEMALE:	23c	. If yes, ou	tcome of pr	egnancy							23d. Date of c	lelivery
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?			oirth 2 🗍		☐Ectopic p		<i>y</i>				Month	Day Year
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<u>α</u>	The law requires that the tte has been signed by the bage 2 should be detache	by Pt	Part II. Other significant condition	s contri	buting to d	leath but no	t resulting in the	underlying	cause giv	en in Part	I.	23e. Did	tobacco u	ise contribute	to the cause of death?
Records,	quires n sign											1 🗆	Yes 2	<b>Z</b> No 3□	Probably 4 Unknown
Ö	ıw require s been siç s should b	Completed										24a. Was		24b. Were	autopsy findings available o completion of cause of
Re	The law te has age 2	E										perf	ormed?	death	? es 2□ No
Vital		O)	25. Was case referred to medical							26. Plac	e of Deal	h (Check only	one)		
>	2 0	To B	examiner? 1 Tyes 2 No	Hos	spital: 1 🗌	Inpatient	2 ER/Outpat	ent 3□ D	OA Ott	18r: 4 <b>/5</b> /	ursing Ho	ome 5 Res	idence	6 □Other (S	pecify)
J of	ding Ph n. After th funeral	Ë	27. Manner of Death 1 DNatural 5 ☐ Pending		28a. Date (Mor	of Injury oth, Day Yea	ar) 28b. Time	of	28c. Injui Wo			28d. Describe	how injur	y occurred	
ioi	Attending or death.	atle	2 Accident investiga	ition				М		Yes 2	]No	001 1 1	(0)		Des / Beats Mumber
Division	_ @	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed		e of Injury - ling, etc. <i>(S</i> i	At home, farm, pecify)	street, facto	ry, office			City or To			Rural Route Number,
۵	urs af			51	.0: <del></del>			- Ale	d = 2 db = 4:	data a	nd place	and due to the	031150(5)	and manner	as stated
	To the Hospitel or within 24 hours aft To the Funeral Discompletely filled in	edical	29a. Certifier 1 Certifying (Check only 2 Medicel E	Physic xemine	r: On the b	e best of my pasis of exa oner stated.	y knowledge, de mination and/or	ath occurred investigation	n, in my	me, date a opinion, de	ath occur	red at the time	date and	place, and o	ue to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier		anumai	mer stated.		29	c. Licens	se number			29d. Da	te signed (Mo	onth, Day, Year)
	F ≥ F 8			-	V	4		1	D	7375	73		M	CH 2	3, 2008
	Λ		30. Name and address of person v	tho con	pleted cau	ise of death	(Item 23a) (Tvr	e, Print)				tour	, , ,		
	3		30. Name and address of person v		MP	_	5 Ma		57.	Rei	stevs	tour	M	2 211	36
	St	ate	31. Date filed (Month, Pay, Year)	2001			Signature								
	Regist		MAI Z 4	2000	Total State	ENG	st by								

			Please  1 - State Registrar	Type or Prin State of Ma	ryland / Depa		lealth and M	lental Hyg	_	17447
	Physici		1. Decedent's Name (First, Middle, La William Robert	st) Tonkin		····		2. Date of Deat Month May		3. Time of Death <b>2</b> : 20 PM
	/Medio Examin		4a. Facility Name (If not institution, give Sinai Hospital	e street and number) of BaltiM	ore	4b. City, Town, o	or Location of Death	/	4c. County of De	
	Funeral Director		5. Social Security Number 6. S 216-24-3490		(In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min. Jar	8. Date of Birth (Month, Day, uary 3,	1929 Ma	irthplace <i>(State or Foreign</i> Country) 1 ry Land
	Aaryland f show	or	Usual Residence of Decedent  10a. State  10b. County  Maryland  Baltimo:	re	10c. City, Town or Lo					10d. Inside City Limits 1 Yes 2 No
	with the hard a or 28a-	Direct	10e. Street and Number 731 Silver Creek		111001111	10f. Zip Code 21208	<del>* •</del>		Og. Citizen of What C	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Madical Exacting must be retilized at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ፟ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent B Amed Forces? 1 XYes 2 N	lo l		Hispanic Origin? (Sp an, Mexican, Puerto Specify:		14. Race - Am Black, Wh	nerican Indian,
21215-0036	within 72 hou ene. than "natura	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12th		+) (Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of work d)	ing	16b. Kind of Busines Tastykake	
Maryland 2	uld be filed Mental Hygi rked other tic event, the	To Be Co	17. Father's Name (First, Middle, Last John Henry Tonkii			- Dares	18. Mother's Nam	e (First, Middle, I	Maiden Sumame)	
	and 2 shousalth and No. 27 Is mai		19a. Informant's Name/Relationship Mrs. L. Fern Tonl		e) 731 S	Silver Cr	eek Road,	Pikesv	, City or Town, State, ille, MD 2	1208
Baltimore,	Pages 1 tment of He tant: If iten jury or oth		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special Content of	fy) I	ruid Ridge	natory or other pla e Cemeter	<sup>сө)</sup> у Мау 24,	2005 1		, Maryland
Ba	permit Depar Impor any in		21. Signature of Funeral Service Lice	colner M	∞333 87	728 Liber	ty Rd., F	Randalls	town, MD 2	Directors, 1133-4784
	rhysician /Medical Examiner		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Acute	the death. Do not ent e.  Myo card i a consequence of):			or respiratory arr	est,	Approximate Interval Between Onset and Death
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.O. Box 6876	The law requires that the death certificate be exate has been signed by the attending physician page 2 should be detached for use as the burian	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	⊒Ectopic pregnanc	у		23d. Date of d Month	elivery Day Year
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of Vital	Physician: The lav this certificate has ral director, page 2 a	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie		IL 3 DOA	-	ome 5 Reside	ence 6 □Other (Spow injury occurred	pecify)
Division	Attending in death. ector: After by the fune	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not I determined	(Month, Day	r Year) Injury	M 1	rk? ]Yes 2 □ No		treet and Number or	Rural Route Number,
۵	Hospital or 24 hours afte Funeral Dir tely filled in	Medical Cer	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of	examination and/or in	h occurred at the ti	ime, date and place, opinion, death occur	and due to the c	ause(s) and manner late and place, and d	as stated. ue to the cause(s)
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	1,9		30. Name and address of person who Eilen Zingw	an D.O.	Sinai t	Print) tospital	of Balti	more		
	Sta Regist		31. Date filed (Month Pay. 1200)	32. Registra	ar's Signature					

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n of Vital Records, P.O. Box 68760,	Attending Dhysician: The law requires that the death cedificate be executed
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ivision	or Attending

		1 - State Amend Item 191 Registrar  1. Decedent's Name (First, Middle, Last)		-			2. Date of De	ath	Year	3. Time of Deat
ysicia		Henry Lee Walla	ce				Month & 5	20	2005	8:451
/ledic amin		4a. Facility Name (If not institution, give si			4b. City, Town,	or Location of De	47	4c. Cc	ounty of Deatl	h
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eral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birth	Months Davs		in. (Month, Da	ıy, Year)	Co.	hplace (State or For untry)
tor		213-60-3449	49		rs.		01/11/1	L956	Mary	land
si .	}-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Lin
9	Į,	Maryland		Ra1	timore					1 <b>∑</b> Yes 2□
100	Directo	10e. Street and Number		Dai	10f. Zip Code			10g. Citize	n of What Co	untry?
and and		5807 Hillen Road	Apartmen	t L	21239	9		U.S.		
NI JA	Funeral	11. Marital Status	12. Was Decedent Example Forces?		13. Was Decedent of If Yes, specify Cub	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	)- 14	. Race - Ame Black, White	
a la	by Fu	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	)	1 ☐ Yes 2 🛱 No	Specify:		S	pecify: B1a	ick
N I	ed b	15. Decedent's Educ		16a.	Decedent's Usual Occu	pation		16b. Kind	of Business/	Industry
Ve dic	plet	(Specify only highest grade	completed) College (1-4or 5+		(Give kind of work done life. DO NOT use retire	e during most of v ed)	vorking			
2	Completed	8	College (1-401 54	'	Musician			Musi	ic	
vant,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle	, Maiden St	umame)	
#ice	To	Charlie Wallace				1	e McNeil			
an m		19a. Informant's Name/Relationship (Typ			Mailing Address (Stree			1.		
er tr		Kirby Wallace / Bro	tner		28 Bridgeha	mpton Dr	Date Apt		tion - City or	
r of		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemeter)	Disposition (Name of y, crematory or other pla	ace)	Date	200. L00a	tion - City of	Town, State
ury		4 □ Donation 5 □ Other (Specify)		Mt. Zi	on Cemeter					, Marylan
any injury or other traumatic event, the Medical Evant art must be notified at once.		21. Signature of Funeral Service License	90		22. Name and Addr					
2 G		Many 1	C-12		4611 Park	Hgts. A	ve., Bal	timore	e, Mary	yland 212
-		23a. Part1. Enter the disease, or compli								Approximate
-	l i	shock, or heart failure. List only on	ne cause on each line	the death. Do n e.	not enter the mode of dy	ring, such as card		arrest,		
ian		Immediate Cause (Final disease or condition	ne cause on each line	э.		ring, such as card	liac or respiratory a	arrest,		Interval Between
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я	Physici	an	Decedent's Name (First, Middle	, Last)				2. Date of Deatl Month	h Day Year	3. Time of Death
н	/Medic			Zollie_	Wood	dson		May	18 2005	8:00p. M
	Examin	er	4a. Facility Name (If not institution	-			r Location of Deatl	h	4c. County of Dea	ith
			7101 Brompton	Road		Baltimo	ore			
	Funeral Director		5. Social Security Number  241-52-9826  Usual Residence of Decedent	6. Sex 7. Ag	ge (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		9. Bir	thplace (State or Foreign ountry) NC
	and W		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	f sho	ō	MD M	7						XIXYes 2 □ No
	28a-	Director	MD N2  10e. Street and Number	A	Baltimo	10f. Zip Code		10	g. Citizen of What Co	
	with a or									ouritry :
	eath	era	7101 Brompton	n Road 12. Was Decedent	Ever in II S 13	Was Decedent of Hi			U S A	oriona Indian
	ter d	Funeral	1 □ Never Married 2 □ Marri	Armed Forces?	No.	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puert	to Rican, etc.)	Black, Whi	
ž	ours after death with the Marylan rel', or items 23a or 28a-f show Exercities must be notified at	by	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	Black
215-0036	172 hours after death with the Maryland "neturel", or Items 23a or 28a-f show "lical Exercites the nutified at	Completed	15. Decedent	's Education	16a. Dece	dent's Usual Occupa	ation	1	6b. Kind of Business	/Industry
7	within 7 lene. than "n	ple	(Specify only highes Elementary/Secondary (0-12)	College (1-4or	life.	kind of work done o DO NOT use retired	furing most of wor f)	rking		·
7	d with	E O	12th grade	2yrs		perviso	r	נ	niform (	Company
פ	othe	Bec	17. Father's Name (First, Middle,	Last)			18. Mother's Nar	пе (First, Middle, N		
and	Alenta Alenta rked tice	To E	Zollie Jeffer	rson			Jõhnsie	e Stewar	:t	
Mary	should and Men a marke umatic	١,	19a. Informant's Name/Relationsh	. Æ 8:4	hew 19b. Mailin				City or Town, State,	Zip Code)
	alth alth 27 ii		William E. C	rutchfield	9525	Quarry	Bridge	e Ct, Co	lumbia,	Md 21046
altımore,	es 1 and of Healt fitem 2 r other		20a. Method of Disposition		20b. Place of Dispo cemetery, crei	sition (Name of	(4)	Date 2	Oc. Location - City or	Town, State
Ë	0 0		1 X Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (St					/27/05 0	wings Mi	11a Ma
	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service I	Ligensee /	22	2. Name and Address	ss of Facility	/2//05	wings mi	.IIS, Ma
ñ	Per Per Per Per Per Per Per Per Per Per		Mein	25K 1	Ma	rch F/H	West	D - 3 t- 4		01015
	1		23a. Parti. Enter the disease, or	complications that	d the death. Do not ent	er the mode of dying	g, such as cardiac	Baltim or respiratory arre	ore, Ma	21215 Approximate
			shock, or hea to ilure. List	only one cause on each li	ine.		MAUNI	10.67	20000 0	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Kt	200 SCIE	NOTO 1	ANDIOVA	BUILD F	recise	Doysemie
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9	certificate iding phys	0		0.						
XON	eath certific attending p	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	livery
ň	death e atten od for u	clai	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a		Ectopic pregnancy Other (specify)			Month	Day Year
o.	y the	ysi	9 Unknown	9□ Unknown						
7	requires that the de een signed by the a nould be detached f		Part II. Other significant condition	ns contributing to death t	out not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
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ě	e ta has	ш						24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
Ö									No 1 ☐ Yes	2 □ No
VITal	yaicien: is certific director,	Be	25. Was case referred to medical examiner?	Hospital:		othe Othe	05	ath (Check only one	)	
ō		-T	1 Yes 2 No 27. Manner of Death	28a. Date of Inju		IL SEL DOA	4 🗆 Nursing n	lome 5 Resider 28d. Describe how	nce 6 Other (Spe	cify)
	ding Phy h. After thi funeral	loli	1 Natural 5 ☐ Pending	g (Month, Da	y Year) Injury	Work	Yes 2□No	280. Describe nov	w injury occurred	
<u>s</u>	deatl ctor: / the	ica	2 Accident investig	not be	jury - At home, farm, str		162 5 140	29f Leasting (Ctr	and and Alice beautiful	
DIVISION	or A after Direction by	ertification;	4 ☐ Homicide determi		ic. (Specify)	eet, ractory, onice		City or Town,	eet and Number or Ru State)	urai Houte Number,
-	pitel ours erel filled	O	29a. Certifier 1 Certifyin	a Physician: To the best	of my knowledge, death			1		
	Hos 24 hc Fun stely	edical	(Check only 2 Medical I	g Physician: To the best Exeminer: On the basis o and manner st	it examination and/or in	n occurred at the tim vestigation, in my of	ie, date and place pinion, death occu	rred at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)
	To the Hospitel or Attending Pl within 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	Med	29b. Signature and title of certifier		atou.	29c. License	number	20	d. Date signed (Mont	h. Dav: Year)
	F ≯ F 8 /		TO1101	FKIMA	1110	7.3	7021	,	05/27	100
			20 Name and address of			Dian)	1000	2 (	0 1/26	1/03
	り		30. Name and address of person of St. Date filed (Marth Star Year)	ANC MD	4510 (	iberty !	lats Are	BAU	more, M	D 2/207
	Sta Registr		31. Date filed (Month, Pay, Year)	4 2005 32 Registr	rar's Signature	seles /				,

			For State Registrar		State of Ma			ent of F ate of i		Mental Hy	giene Reg. No.	. 000	17450	
			Decedent's Name (Fi	irst, Middle, Last)						2. Date of De	aath		3. Time of Death	_
	Physicia		CHARLES,	ANTHO	VY WAGE	RMAN	1			Month	つ Day		5 5:45 PM	
	/Medic Examin		4a. Facility Name (If not			,, =, -, -, -,		City, Town, o	r Location of Dea			County of Deal		
			BALTIMORE	VA ME	EDICALC	ENTER		BALT	IMORE					
Ī	Funeral		5. Social Security Numb	er 6. Se		(In yrs. last birti	nday) If U	nder 1 Year ths Days	If Under 24 Hrs Hours Min	8. Date of Bi	rth av. Year)	9. Birt	thplace (State or Foreign	7
	Director		V 1 - 0 -	700	<b>(</b> M 2□F	78 <sup>\</sup>	rs.	uis Duys	110013	April 19	,1927	Ehmit	tsburg, MD.	
	Du k	1	Usual Residence of Dec 10a. State 10t	b. County		10c. City, Town	or Location						10d. Inside City Limits	_
	e d a	5	MD	Baltimo	re	Dunc							1 □ Yes 2 No	
	the A	ect	10e. Street and Number					. Zip Code			10g Cit	izen of What Co	ountry?	_
	with le or	₫	6721 Bosto		2		1.0	21222			_	JSA	,	
	should be filed within 72 hours after death with the Maryland nd Mantal Hygiene. I marked other than "neturel", or Items 23e or 28e-f ehow umatic event, It a Madic Examit of items.	Funeral Director	11. Marital Status	AT AVCITOR	12. Was Decedent E	ver in U.S.	13. Was D	ecedent of H	lispanic Origin? (	Specify Yes or N		14. Race - Ame	erican Indian,	
2	r Iter	필	1 Never Married	2 Married	Armed Forces? 1 XYes 2 ☐ N	0	If Yes,	specify Cuba	an, Mexican, Pue	rto Rican, etc.)		Black, Whit		
3	ours a	þ	3 ☐ Widowed 4 ☐	]Divorced	If Yes, Give Year or Dates:		1 🗆 🕶	s 21X No	Specify:			Specify: Wh	ite	
ה ה	72 hc	Completed		Decedent's Edu		16a.	(Give kind c	Usual Occup	during most of wo	orking	16b. K	ind of Business	/Industry	
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7	ygier ygier her th		12 years			Ca	rpent	ers Un		(F)	4	cal 101		
Jana	be fi	Be	17. Father's Name (Firs							me (First, Middle	, walden	Sumame)		
Ž	natic	2	Charles Wa		one Cointl	10h	Mailine Ada	Jana (Stroot	Edna Br	awrier	City o	Tour State	Zin Code)	_
2	01 44 20 0		Madeline W		wij					Dundalk,			Sp Code)	
υ U	ss 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. I flem 27 is marked other than "neturel", or Items 23e or 28e-f show rother treumatic event, Ite Medic. Examinating the matter at the matter and the matter at the mat		20a. Method of Disposit			20b. Place of	Disposition	(Name of		Date		ocation - City or	Town, State	_
2	permit. Pages : Department of H Importent: If Ite any injury or ot		1 X Burial 2 □ Ci 14 □ Donation 5.□	remation 3 🗆 F	lemoval from State	Oak La	i, crematory wn Ce	or other place metery	May	25,2005	Dune	dalk,MD	•	
paltimo	artme orten injur		21. Signature of Funera		90		. 22 Nam	e and Addre	ss of Facility		-	7 11 D :		-
מ	permi Depar Impor any ir		· \ ~		11~		Con 711	nelly 0 Soll	Funeral	Home Of it Road,	Dune	daik,P.A	21222	
			23a. Part1. Enter the d shock, or heart fai	isease, or compl	ications that caused	the death. Do n						====	Approximate Interval Between	_
	Physician		Immediate Cause (Fina		LARGE				AMOH				Onset and Death	
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2/00	eath certificate be executed attending physician and for use as the burial-transit	dicai			d									_
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X Q Q	atten for us	ian	23b. Was decedent pre in the past 12 mor	oths?	1 ☐ Live birth :	2 Fetal death		ic pregnancy r (specify)	1			23d. Date of del Month	Day Year	
j	requires that the death een signed by the atter hould be detached for u	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9	9□ Unknown	anio oi doda	o 🗀 Otine	1 (Specify)						
ī.	that the	y Ph	Part II. Other significar	nt conditions co	ntributing to death bu	t not resulting in	the underly	ing cause giv	en in Part I.	23e. Did	tobacco i	use contribute to	the cause of death?	
ds	uires n sign	d by								1 🗆	Yes 2	<b>13</b> No 3 □ Pr	robably 4 Unknown	1
cords	> 0 0	lete								24a. Wa	s an	24b. Were at	utopsy findings available	,
Ž Ž	0 1 0	Completed									ormed?_	prior to death?	completion of cause of	
Ö	iclen: Th certificate rector, pag	a	25. Was case referred	to medical			_		26 Place of De	1 ☐ Yes	2 No	1 🗆 Yes	2 No	
>	ysiclen: is certific director,	0 B	examiner?	_ ⊢	lospital:	nt 2 ER/Out	patient 3E	Don Dth	an	Home 5□Res		6 □Other (Spe	cifv)	
0	등 등급	n: T	27. Manner of Death		28a. Date of Injur (Month, Day		ime of	28c. Injur Wor		28d. Describe			,,	ī
0	ath. r: Alter i	atio	2 Accident	Pending investigation	(Worth, Day	1041)	М		Yes 2 □ No					
DIVISION	r Attender death rector:	Certification:	3 Suicide 6	Could not be determined	28e. Place of Inju	ry - At home, far . (Specify)	m, street, fa	ctory, office		28f. Location City or To			ural Route Number,	
5	itel o irs aft rel Di led in		4											
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	(Check only 2		sician: To the best oner: On the basis of	examination and								
	the the mplet	Med	one) 29b. Signature and title	of contitue	and manner sta	ted.		29c. Licens	e number		29d Da	te signed (Mont	th Day Year)	
	M T S		Los, orginaturo and title	Mul	1	PA		D10	26/11		NN N	1 20		
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	1.		30. Name and address	NIZIE		ENITE	Type, Print)	CM	RAIT	THAND	= 1	A MAER	DICAL CENTE	<u>-</u> r
	Sta	te	31. Date filed (Month, D	Day, Year)	32. Registra	r's Signature	1	4 4 - Part	. 2/101	who is now	<u> </u>		SIAIT CEINE	_ <
	Registr		84.03/	a A anne	. D	B. 1	and !	,						
			WAT	WA TANA	L. Carrier Was		-							

			1 - For State Registrar	State of Marylar	•	artment of Healt		lygiene Reg. No:		17451
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Dorys Lorraine	Womack			2. Date of May 2		05 Year	3. Time of Death 1:28 A.M.
-	Examir		4a. Facility Name (If not institution, give s Malcolm Grow Medi	treet and number) cal Center		4b. City, Town, or Locat AAFB	ion of Death		County of Death Prince Go	eorge's
	Funeral Director		5. Social Security Number 6. Sex 577 18 9816	M 2 F Cnk	last birthday) Yrs.	If Under 1 Year If Un Months Days Hou	order 24 Hrs. 8. Date of Min. Feb 2	Birth Day, Year) 8, 192	9. Birthp 21 Wasi	place (State or Foreign ntry) nington DC
	aryland show		Usual Residence of Decedent  10a. State 10b. County		ty, Town or Lo				1	Od. Inside City Limits
	vith the Mi	Directo	Maryland Prince Ge  10e. Street and Number  5804 Delt		Camp	Springs 10f. Zip Code		-	izen of What Cour	•
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 le marked other then "naturel', or Items 23a or 28e-f show my highly or other traumatic event, the Medical Exam for must be notified at ance.	Completed by Funeral Director		2. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:		20746 Was Decedent of Hispanic f Yes, specify Cuban, Men 1 ☐ Yes 2 🛣 🎖 Spe	dican, Puerto Rican, etc.)		ited Stat  14. Race - Americ Black, White,  Specify:	an Indian,
Maryland 21215-0036	in 72 hou n "nature dedical E	pleted	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occupation kind of work done during DO NOT use retired)	most of working	16b. Ki	nd of Business/Ind	dustry
1212	12 should be filed within "h and Mental Hygiene." 7 le marked other then "r raumatic event, the Mad		Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	Coilege (1-4or 5+)	Medic	al Secretary	lother's Name (First, Midd		cious	
yland	wild be f Mental P arked of atic ever	To Be	Edwin Bidleman	Warren			heresa Louis			
	1 and 2 sho Health and I em 27 le ma other traums		19a. Informant's Name/Relationship (Ty) Carol J. Baxter (			ng Address <i>(Street and Nu</i> Hwy90, Cott				Code)
nore,	Pages 1 and the control of Hecontrol Hecontrol Hecontrol Hecontrol Hecontrol Hecontrol Hecontrol Hecontrol Hecontrol Hecontrol Hecontrol Hecontrol Hecontrol Hecontrol Hecontrol Hecontrol Hecontrol Hecontrol Hecontrol Hec		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, crer	sition (Name of natory or other place)	May <sup>D</sup> 24,		cation - City or To	
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(1215-U036 within 72 hours after death with the Maryland one. then "natural; or Items 23s or 28e-f show he Maryles I famous 23s or 28e-f show he Maryles I Examiner must be notified at	by Fune	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	If Yes, sp	edent of Hispanic Origin? ( ecify Cuban, Mexican, Pue 2 No Specify:	Specify Yes or No- rio Rican, etc.)	14. Race - Americ Black, White, Specify:	
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Maryis d 2 should th and Mer 7 is marke treumatic		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Addre	ss (Street and Number or R	lural Route Number, City	or Town, State, Zip	Code)
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or Healt		20a. Method of Disposition		Place of Disposition (N. cemetery, crematory or	ame of other place)	Date 20c. L	ocation - City or To	own, State
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Dermit. Par Department Importent: any injury once.		21. Signature of Funeral Service Lice	Delet	22. Name: Brack 2/34	Hey - ASH 6.	I FUNERAL	Home, 21222	P.A.
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the d	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown				Month	Day Year
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ician: Th	e C	25. Was case referred to medical			26. Place of De	ath (Check only one)		
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tune fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
JONISION  For Attending after death.  Director: After fin by the fune	fica	3 Suicide 6 Could not b	28e. Place of Injury - At I	nome, farm, street, facto		28f. Location (Street a	nd Number or Rura	l Route Number.
rs after	Certification:	4 Homicide determined	building, etc. (Spec	ity)		City or Town, State		
To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier Check only one) Certifying Pl	nysicien: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death occurre ation and/or investigation	d at the time, date and place n, in my opinion, death occ	e, and due to the cause(s urred at the time, date an	and manner as st d place, and due to	ated. the cause(s)
To th withir To th	Me	29b. Signature and title of certification		25	c. License number	29d. Da	ite signed (Month,	Day, Year)
/		· //-	-m()	F	18580	S	117/0	)
5		30. Name and address of person who	completed cause of death (Ite	om 23a) (Type, Print)	eet Bait.	min min	2/20/	
St	ite	31. Date filed (Month, Day, Year)	32/Registrar's Sign	the South	LLT DALT	more, MO	21201	
Regist		MAY 2, 4 20	05 Keeper	1. Sparke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** William Edward Wallace, Jr. May 20, 2005 1:30P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Potomac Valley Nursing Home Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New York 8. Date of Birth (Month, Day, Year) Months Days M ZMF Hours Min. 68 113-30-2946 26, 1937 Mar. Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20688-3132 801 Runabout Loop United States 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 Ĭ No Specify: þ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Electrical Engineer U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William E. Wallace, Sr. 2 Esther Vanborg Nielsen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William E. Wallace, III/Son 107 Upton Street, Rockville, Maryland 20b. Place of Disposition (Name of cametery, crematory or other place)
Montgomery 20a. Method of Disposition 20c. Location - City or Town, State May 24 1 □ Burial 2 A Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2005 Crematorium, Inc. Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 755/ Wisconsin Avenue Bethesda, Maryland 20814-3501 eral Service Lile see 21. Sign San M00803 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) irrhosi ew yr Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 20 No 3 Probably 4 Unknown thena boura 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 1□ Yes 25 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

be executed Box 68760. The law requires that the death certificate P.O. Records, of Vital or Attending Physicien: Division

**Funeral** 

Director

Hygiene. other then "naturel", or Items 23a or 28a-f show ent, the Madical Examinat must be notified at

other

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is eny injury or other trau

Physician

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Baltimore, Maryland 21215-0036

within 24 hours a
To the Funerel Completely filled Ŏ 3

State Registrar 31. Date filed (Month, Day, Year) MAY 2 4 2005

29b. Signature and title of certifier



and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

2401

Research

29d. Date signed (Month, Day, Year)

TOOK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 5 1- State Amend Item 19a-b per fh G843 5-24-05 tas Death Registrer 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 05:05 M Year **Physician** WARSHAW MARTIN 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LOSPITAL BACTIMORE SINAL BALTIMORE CITY. OF | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | 07/31/1928 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 1 M M 2 □ F **Funeral** 101-20-1448 Director 76 N.Y. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23c or 28e-f show any injury or other treumatic event, the Medical Ever in errorative profits of an once. 10a State 10b County 1 ☐ Yes 2 🔀 No Director MD HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21045 9322 WILD BEES LANE U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Anned Forces? 1 1 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 🛣 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry thent leaven Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN MANUFACTURERS REP. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WARSHAW SADYE BERGMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9322 WILD BEES LANE COLUMBIA, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State COLUMBIA MEMORIAL PARK 05/22/2005 \* 4 ☐ Donation 5 ☐ Other (Specify) COLUMBIA, MD 21. Signature of Faneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate
Interval Between
Onset and Death
- U eecs 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SLPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Phermonia 2-4 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-transit Guilore Respiration weeles resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Division of Vital Records, P.O. Box 68760, ears clisease Physician/Medical oronery IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Kibeles pertension wand 1 weckin 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ZUnknown Completed certificate has been uleer urinan muet infection decombis 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1 Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred B Hospitel or Attending Pl 24 hours after death. Funerel Director: After the 1 Natural 5 Pending 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel of within 24 hours at To the Funerel D 29a. Certifier 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier M.D. RES - 000 May 2005 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) HUSPITAL OF M.D BLACTIMORE LUM 32. Registrar Signature State 4 Registrar

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		State of Maryland / Dep	eartment of Health and Mertificate of Death	lental Hygie	ege0 0 5	17455
Physic	ian	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
/Med	ical	William L. Young		May	22 2005	11:55P M
Exam	iner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
- Control		Charlestown Care Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Catonsville  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Baltimo:	re place (State or Foreign
Funera Director		122-14-5750 1⊠M 2□F 78 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, ) May 31,	1926 New	York
70		Usual Residence of Decedent				
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Ba-f	ecto	Maryland Baltimore Caton	sville			1 ☐ Yes 21 No
with t	D.		10f. Zip Code 21228	100	g. Citizen of What Coul	ntry?
eath na 23	erai	707 Maiden Choice Lane Apt7G03  11. Marital Status 12. Was Decedent Ever in U.S. 13		ecify Yes or No-	U.S.A.	can Indian
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene, and Mental Hygiene, is marked other than "natural", or Itema 23a or 28a-f ehow aumatic event, the Medical Evanirer must be redified as	by Funeral Director	1 Never Married 2 Married 1 X Yes 2 No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, White,	etc.
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21215-0036 d within 72 hours aft giene. er than "natural", or . Its Medical Exem	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing	8b. Kind of Business/In	dustry
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<b>Baltimore,</b> permit. Pages 1 ar Depertment of Hea Important: If item any injury or otha		'4 □Donation 5 □Other (Specify) Garrison				s, Maryland
<b>Balti</b> permit. I Depertm Importar any injur		21. Signature of Euroral Shiprice Licensee	2. Name and Address of Facility  1tzke Funeral Home	of Cator	nsville, Ir	nc.
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Pnysician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)		or respiratory arres	ι,	Interval Between Onset and Death
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	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie			ce 6 □Other (Specif	v)
Jing Jing After funer	ation:	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation 28a. Date of Injury (Month, Day Year)	of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how	injury occurred	
DIVISION OT  I or Attanding Phy after death. Director: After this in by the funeral d	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
DIVISION  To the Hospital or Attano within 24 hours after deatt To the Funaral Director: completely filled in by the	Medicai C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, ovestigation, in my opinion, death occurr	and due to the caused at the time, date	se(s) and manner as st a and place, and due to	ated. the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month,	Day, Year)
		my ma	P.30989	M	Mu. 23	2005
		30. Name and address of person who completed cause of death (Item 23a) (Type	D30989 Maiden Choice		7	
13		Mylam Carpenter MD 711	Maiden Choice	e Ln c	Catonsvi	110 MD
St Regist	tate trar	31. Late filed (Montp., Day, Year) 32. Jegistrar's Signature				
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		ORIGIN	AL			

			1 = For State Registrar		Maryland / De	partment of Certificate of		d Mental Hy	giene Reg. No.200	5 17456
	Physici	an	Decedent's Name (First, Midd	le, Last)				2. Date of De Month	aath Day Yea	3. Time of Death
1	/Media	cal	Fern	С.		bott		May	19 2005	
1.	Examir	ıer	4a. Facility Name (If not institution  Anne Arunde1		•		or Location of D	Death	4c. County of D	
	Funeral		5. Social Security Number		lter Age (In yrs. last birtho		polis r   If Under 24	Hrs. 8. Date of Bir		Arundel
	Director		183-18-6083	1 ☐ M 2 💢 F	83 Yrs	Months Davis		Vin. (Month, Da		Birthplace (State or Foreign Country) Pennsvlvania
	p ,		Usual Residence of Decedent					110222		
	anyla shov	5	MD Anne		10c. City, Town o					10d. Inside City Limits
	the M	Director	10e. Street and Number	e Arundel	Shad	y Side				1 ☐ Yes 2 No
	with the or	2	4744 Frederic	ale Arramus		10f. Zip Code			10g. Citizen of What	Country?
	Jeath ms 23	Funeral	11. Marital Status	12. Was Deceder	nt Ever in U.S.	3. Was Decedent of		? (Specify Yes or No	USA 14. Bace - A	merican Indian.
9	after or Itel		1 Never Married		s?	If Yes, specify Cu	ban, Mexican, P	uèrto Rican, etc.)	Black, W	hite, etc.
21215-0036	72 hours after death with the Maryland naturel', or Items 23a or 28e-1 show dreal Examiner must be notified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates	: WWII	1 □ Yes 24 No	o Specify:		Specify:	White
5	"natu	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)	16a. De	ecedent's Usual Occu live kind of work doni e. DO NOT use retir	upation e during most of	working	16b. Kind of Busine	ss/Industry
12	within ene. then	dmo	Elementary/Secondary (0-12)	College (1-4o	r 5+)	e. <i>bo nor u</i> se <i>retir</i> emaker	rea)		0 11-	
<b>d</b> 2	be filed within 72 hours after death with the Marylar tal Hygiene. ed other then "naturel", or Items 23a or 28e-1 show outlet then "naturel", or Items 23a or 28e-1 show event, the Macical Examiner must be notified at		17. Father's Name (First, Middle,	Last)	Home	ещакет	18. Mother's	Name (First, Middle,	Own Home , Maiden Sumame)	
an	lid be lental rked c	To Be	Hobart Heller	2			Beula	h Slaybau	gh	
Maryland	d 2 should be filed within th and Mental Hygiene. 7 Is marked other then treumatic event, the M		19a. Informant's Name/Relations	ship (Type, Print)	19b. M	ailing Address (Stree			er, City or Town, State	, Zip Code)
	オイトコ		William Abbot	t (Husband)				ue, Shady	Side, MD	20764
Baltimore,	of of in		20a. Method of Disposition XXBurial 2 ☐ Cremation	3 □Removal from Stat	20b. Place of Di cemetery,	sposition (Name of crematory or other pl	lace)	Date	20c. Location - City	or Town, State
Ë	Pag tment tent: jury c		4 ☐ Donation 5 ☐ Other (5	Specify)		ille Cemet		23/2005	Biglervill	e, PA
Bal	permit. Pag Department Importent: eny injury c		21. Signature of Fune II Service	Licenses		22. Name and Add Hardest 12 Ridg	y Funer	al Home, I	P.A. polis, MD	21401
ı			23a. Part1. Enter the disease, o shock, or hear failure. List	r complications that caus tonly one cause on each	ed the death. Do not line.	enter the mode of dy	ring, such as care	diac or respiratory a	rrest,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	_ a.		Emphyse	ma			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	is a consequence of):	h. 33				V
		<u>-</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or a	is a consequence of):					
	uted I Insit	Examine	Cause (Disease or injury	<						
Ć,	s be executed sician and burial-transit	Еха	that initiated events resulting in death) Last	Due to (or a	s a consequence of):					
8760,	death certificate be executed e attending physician and of for use as the burial-transit	cal		d						
9	rtifica ng ph	Med	IF FEMALE:							
Вох	eath certific attending p	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐Live birth		3 □Ectopic pregnanc	cy		23d. Date of d	,
0.	at the dea by the a tached for	Physician/Medical	1 ☐ Yes 2 🗗 No 9 ☐ Unknown	4∏Pregnant 9☐ Unknown	at time of death	5 Other (specify)			Month	Day Year
<b>Q</b>	de de		Part II. Other significant conditi	ons contributing to death	but not resulting in th	e underlving cause o	iven in Part I.	23e. Did to	obacco use contribute	to the cause of death?
of Vital Records,	uires sign	d by				, , , , , , , ,				Probably 4 □Unknown
CO	w requir s been si should	ompleted						24a. Was	an 24b Were	autopsy findings available
Re	: The lav	mo						autop perfo	osy prior t death	o completion of cause of
ital		3e C	25. Was case referred to medica	I II			26. Place of I	1 ☐ Yes Death Check on o	2 KNo   1 □ Yo	es 2 No
Ť V	di S	To B	examiner? 1 □ Yes 2 <b>Š</b> No	Hospital: 1 Kinpai	tient 2 ER/Outpa	tient 3 DOA			dence 6 □Other (Sp	pecify)
D C	ng Pl		27. Manner of Death 1 Natural 5 ☐ Pendir	28a. Date of In (Month, D	jury 28b. Time ay Year) Injur				now injury occurred	
sio	Attending ir death. ector: After by the fune	cat	2 Accident investi	gation not be			]Yes 2 □No			
Division	i di fi	Certification:	4 Homicide determ	nined 286. Place of I	nj <i>ury -</i> At home, farm, atc. <i>(Specify)</i>	street, factory, office	)	28f. Location (S City or Tow	Street and Number or . vn, State)	Rural Route Number,
	PL T	edical (	29a. Certifier 1 Certifyir (Check only one)	ng Physician: To the bes Examiner: On the basis and manner:	or examination and/or	ath occurred at the t investigation, in my	time, date and pla opinion, death o	ace, and due to the occurred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifie	1601	4	29c. Licen	Dugost		29d. Date signed (Mo	
	~		Mre	ulbech, M	W	1	DAGOSE		5/19/	or
	12		30. Name and address of person Special Be	who completed cause of $\mathcal{U}$ , $\mathcal{W}$ 20	death (Item 23a) (Typ 0 ( Weal) (A	9. Pronkway	anna	ipolis, ru	D	
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 2 5	32. Regis	trar's Signature	back				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Yea BYRD KOBERT 7-00 A M /Medical 2005 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Funeral Birthplace (State or Foreign Country) 1 M 2□ F 5 5489 Days Hours 0-Director Usual Residence of Decedent 10a State 10b. County City, Town or Location 10d. Inside City Limits other traumatic avant, the Medical Examiner roust be nutified at Be Completed by Funeral Director 1 Yes 2 □ No nore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married Married Yes WNo f Yes, Give fear or Dates: 1 ☐ Yes 2 💢 o 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industr permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "na any injury or other traumatic avant, if a M-cit. once. dary (0-12) College (1-4or 5+) Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 19b. Mailing Address (Street and Number or Rural Route Number, City or 1 to -MD 2 Place of Disposition (Name cemetery, crematory or other thod of Disposition Baltimor **2**8urial 2 ☐ Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Rd . 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** astan disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death Month Day 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 2 X No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 📋 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of Certification: 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No after death Diractor: / 6 Could not be determined 3 📋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral C completely filled it Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Pay, Year) m D 35082 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ORL STREET SALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** 1:00 PM Thomas Henry Brown, Sr. 21 2005 man /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center
5. Social Security Number | 6. Sex | 7. Age (In vrs. last Harford Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 1□M 2□F New Jersey 80 Director 143-16-4078 Sept. 27, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at Abingdon 1 ☐ Yes 2 No Md. Harford Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21009 U.S.A. 3714 Woodsdale Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married white 1 ☐ Yes 2 ☐ No Specify: Specify: ð Baltimore, Maryland 21215-003 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) truck driver distribution 12 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 12 should be f and Mental F is marked of unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a, Important: If Item 27 is any injury or other trat once. 5266 Pinto Way, Orlando, FL 32810 Thomas H. Brown, Jr./son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 5/24/05 Baltimore, Md. Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as a consequence of): **Examiner** trial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of): attending physician and for use as the burial-transit er bro variale accord Due to (or as a consequence of) of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) \_ ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4. Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Mellitus 24a. Was an Diuletes autopsy performed2 2 🗆 No 2 No 1 Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dire 1 ☐ Yes 2 ☐ No 2 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 27. Manner of Death 28d. Describe how injury occurred Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 5/22105 and address of person who completed cluse of death (Item 23a) (Type, Print) by Neguib, Mb 2 Colgate Drive Forest Hill MA 21050 (nite 20) Aly Noguib, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 5 2005 Registrar

DHMH 17 Rev 1/2001

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, Thomas

		1	For State Registrar	State of I	Maryland /		artment <i>tificate</i>			and M		iene 2 (	005	17	459
			Decedent's Name (First, Middle,	Last)							2. Date of Dear	h Day	Year	3. Time o	of Death
	Physicia /Medic	al L	Phyllis M. Br								May 22			10:1	5 р <sup>м</sup>
	Examin		4a. Facility Name (If not institution, 3333 Scarboro		er)		_ ,	rown, or	Location of				arfo	rd	
	Funeral Director		216-32-4799	6. Sex 7. 1 ☐ M 2 ☐ F	Age (In yrs. last b	irthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Nov. 28	Year) 1935	9. Birth Cou Ma:	place (State intry) ryland	
	and and	)-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	wn or Lo	cation							10d. Inside C	City Limits
	Maryl f sho	ō	Md. Ha	rford				St	reet					1 ☐ Yes	s 2.2.7 No
	r 28e	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of	What Cou	untry?	
	th wit	a D	3333 Scarboro	Road					211			U.S.			
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene importent: If item 27 is marked other then "naturel", or items 23a or 28e-f show appring yor other treumatic event, I'm Middell Exitational Letticiliad at Once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force ed 1 Tes 2 If Yes, Give Year or Date	as? ⊠ No		Was Decedon f Yes, spec 1 ☐ Yes 2		spanic Ori n, Mexicar Specify:	gin? (Spe n, Puerto F	city Yes or No- Rican, etc.)	Bla	ce - Amer ck, White fy: Wh		
21215-0036	vithin 72 ho ne. hen "natur e Medical I	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)	s Education t grade completed)  College (1-4	or 5+)	(Give life.	dent's Usua kind of wor DO NOT us	k doné d e retired	luring mos	t of workir	ng	16b. Kind of B		ndustry	
Maryland 21	d be filed within antal Hygiene.  ced other then " c event, Ire Me	Be	10 years 17. Father's Name <i>(First, Middle, L</i> Joseph Lane	Last)	c	ash	_offi	cer			(First, Middle, ea Prit	Maiden Sumai			
Z.	should nd Men marke imaric	LO LO	19a. Informant's Name/Relationsh	nip (Type, Print)	19	b. Mailir	ng Address	(Street a	and Numbe	er or Rura	l Route Number	, City or Town	, State, Z	ip Code)	
	alth a alth a 127 ls		Dale Brennan/so	on	3	3337	Scarl	boro	Road	l, St	reet, M	d. 2115	54		
Baltimore,	Pages 1 annount of He		20a. Method of Disposition 1  Burial 2  Cremation 1 4  Donation 5  Other (Sp		20b. Place cemete Bel A	ery, crei	sition (Name natory or of Mem. (	ther place	θ)		/2005	Bel A			
Balt	permit. Page Department Importent: If any injury o		21. Signature of Funeral Service L	Licensee	0						Home of ad, Bel				
8760,	Certificate be executed / Medical Examiner and indig physician and itse as the burial-transit	dlcal Examiner	23 art1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Unioritying Cause (Disease or injury that initiated events resulting in death) Last	a	as a consequence as a consequence as a consequence as a consequence	e of):	1	e of dying		eardiac o		est,		Approxima Interval Be Onset and	tween Death
.O. Box 68	death e atter id for u	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live birt	ome of pregnancy h 2 Destal deat ht at time of death n		Ectopic pro						ate of deli	very Day	Year
Δ.	w requires that the been signed by the should be detache		Part II. Other significant conditio	ns contributing to dea	th but not resulting	in the u	nderlying ca	ause give	en in Part I			bacco use con es 2 □ No		the cause of	
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ou c	ding Ph h. After thi funeral	lon	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig		Day Year)	. Time o	M Z	8c. Injun Work	γαι k? Yes 2 🗍		28d. Describe h	ow injury occu	1100		
Division	ppitel or Attending ours atter death. terel Director: After filled in by the fune	Certification;	2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place o	f Injury - At home, p, etc. (Specify)	farm, st					28f. Location (S City or Tow	treet and Num n, State)	ber or Ru	ral Route Nu	mber,
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 Certifyin (Check ont) 2 Medicel	g Physicien: To the b Examiner: On the bas and manne	is of examination a	ge, deat and/or in	h occurred vestigation,	at the tin	ne, date ar pinion, dea	nd place, a	and due to the c	ause(s) and m late and place,	anner as , and due	stated. to the cause	(s)
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6	1				2 South		Print)	Ri	ad a	# 20	xo, Bel	Air, s	MD	21014	
	Sta Regist		31. Defiled (Month, Day, Year) MAY 2 5 2	140	gistrar's Signature	Spen	ري								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 345 **Physician** wrre 2000 drew mai /Medical 4c. County of Death 4b. City Town, or Location of Death 4a. Facility Name (If not institution, give/street and number **Examiner** Medical Center toalt imor saltimore If Under 1 Year | If Under 24 Hrs. | Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours **X**M 2□ F Yrs. MD 24 Director 06 80 217-18-2791 Usual Residence of Decedent should be filled within 72 hours after death with the Maryland of Mental Hyglene. marked other than "naturel", or ltems 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "naturel", or items 23a or 28a-f shov treumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Randallstown MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21133 U.S.A. 3928 Noves Circle Apt 102 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race · American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Building Operation Public Schools 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fill and Mental H Be Anna Mae McWilliams William Burrell ၀ Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21133 Department of Health a Importent: If item 27 is any injury or other tre once. 20b. Place of Disposition (Name of cemetery, crematory or other place)

3928 Noves Circle Apt 102,
Date 200 Randalsltown, Md Helen Burrell-Wife Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State • 4 □ Donation 5 □ Other (Specify) Garrison Forest Vet. 5/31/05 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician YEARS LS CHEMIC ARDIOMYOPATHY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the list of Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Examine law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown ò signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death 24a. Was an certificate has autopsy performed 1 Yes 2 No 1 Yes R No Hospitel or Attending Physicien: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No. 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2

State

Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

HNOWW

31. Date filed (Month, Day, Year)

10N GREENE

mis

32. Registar's Signature

MD

2005

30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

PO15981

BACTIMORE

29d. Date signed (Month, Day, Year)

05

			For State	State of Ma	•	artment of Hertificate of D	ealth and Me			
			Registrar  1. Decedent's Name (First, Middle, La	ist)	Oei	Tincate of L		Reg. No. 1	<del>2005</del>	3. Time of Death
	Physici		CHARLOTTE		BARTHOL	est.			Day Year	3:30 A.M.
	/Medic Examin		4a. Facility Name (If not institution, give		MAKINO	4b. City, Town, or			4c. County of Deat	
	LXamii		MANOR PARS-1	211/20105		ROSSOA	21	(	BALTIME	િલ્
	Funeral				(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Yea		hplace (State or Foreign
	Director		212-22-222	10 M 2 F 7 E	3 Yrs.		3	JA 19 19	26 MAR	DOALK
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Maryl f sho	Į.	MARLAND BALTIN	200	PLOV	2115				1 ☐ Yes 2 No
	the rould	Director	10e. Street and Number	1010	, ALLEN	10f. Zip Code		10g. (	Citizen of What Co	untry?
	h with	ie D	9201 AVONDAL	ROAD		212	34		A.Z.U	
	Itams 2	Funerai	11. Marital Status	12. Was Decedent E	ver in U.S. 13.	Was Decedent of His	spanic Origin? (Specif n, Mexican, Puerto Ric	y Yes or No-	14. Race - Ame Black, White	
98	or Ita		1 Never Married 2 Married	1 ☐ Yes 2 No	o	1 □ Yes 2 No	Specify:	,	Specify:	1
21215-0036	filed within 72 hours after death with the Maryland Hygiene ther than "natural", or Itams 23e or 28e-f show ther, the Medical Examinator must be notified at	d by	3 ☐Widowed 4 ☐Divorced	Year or Dates:	162 Dagg	dent's Usual Occupa	tion	166	Kind of Business/	3/1/
7	in 72 " nat	Completed	(Specify only highest gr	ade completed)	(Give		uring most of working	100.	Kind of Business/	moustry
212	filed with Hygiene. Ither than	шо	Elementary/Secondary (0-12)	College (1-4or 5+	, Ho	MAKS	R		AT HO	W.
	be filed within 72 hours after death with the Marylan ital Hygiene. ad other than "naturat", or Itams 23a or 28a-1 show other than "naturat", or a motified at event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Las.	)			18. Mother's Name (F	First, Middle, Maide	en Sumame)	
/lai	should be filed within and Mental Hygiene. s marked other than umatic evant, I've M	10	CHARLES E.	TRACEY			ELIZABE		_	
Maryland	S a a		19a. Informant's Name/Relationship	Type, Print)	19b. Mailir	0	nd Number or Rural	ute Number, City	or Town, State, 2	Tip Code) 21234
	othar tr		20a. Method of Disposition	RTHOLME	20b. Place of Dispo	HVONOP		AKKY J	Location - City or	Tour State
3altimore,	a to to		Burial 2 Cremation 3		cemetery, crer	natory or other place	1017010	, O	Location - City of	Maria A
Ë			21. ign suf FuniServi Lice	7.1	HAKKWOO	. Name and Address	s of Facility		180 TTE 1	INALANO
Ba	permit. Departr Importa any inji		1 40	7		AUT THE	657 081 12	morries	LIZ MARY	JANO AMA
			23a. Part1. Enter the disease, or con	plications that caused t	he death. Do not ent	er the mode of dying	, such as cardiac or r	espiratory arrest,	TIC I INIT	Approximate Interval Between
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each line		OXIA				Onset and Death
	/Medical		disease or condition resulting in death)	p a Due to (or as a	consequence of):					Dott
п	Examiner		Sequentially list conditions,	b. PE	216HERA	e VA	ScuiAL	DIS	SISE	
	p ti	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence or;					
	and and I-trans	Examiner	that initiated events resulting in death) Last	c	consequence of):				-	
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit									
687	ficate physis the	edicai		_ d	7,577					
Вох	eath certific attending p	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o					23d. Date of deli	ivery
	death	Physician/M	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown		DEctopic pregnancy Other (specify)			Month	Day Year
P.0	that the de led by the a detached	hys	9 🗆 Unknown							
	igned be det	by	Part II. Other significent conditions  A1246	contributing to death but	not resulting in the u	nderlying cause give	n in Part I.		-1	the cause of death?
orc	w require been sig should t	eted	.,	2000		//-		+		
Vital Records,	e law has b	Completed						24a. Was an autopsy performed?	prior to c	topsy findings available completion of cause of
al	ician: Th certificate rector, pag		05.11					1  Yes 2	√o 1 □ Yes	2□ No
<u>Sit</u>	ysician: The is certificate hadirector, page	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	t 2 ER/Outpatier	nt 3 DOA Othe	26. Place of Death (C		6 DOther (Spec	264
of	는 등 등	lan	27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time of		at 280	d. Describe how in		ny)
ion	ath. r: Aft	atio	1 Natural 5 Pending 2 Accident investigation	on	Year) Injury		r res 2 □No			
Division	r Atta ler de iracto	Certification:	3 Suicide 6 Could not l 4 Homicide determined		ry - At home, farm, str (Specify)	eet, factory, office	281	. Location (Street and City or Town, Sta	and Number or Ru ite)	ral Route Number,
	urs af						- 1			
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifics completely illied in by the tuneral director.	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysicien: To the best of miner: On the basis of and manner stat	examination and/or in	n occurred at the time vestigation, in my op	e, date and place, and inion, death occurred	at the time, date a	(s) and manner as ind place, and due	stated. to the cause(s)
	o the	₩ K	29b. Signature and title of certifier	and mailing state		29c. License		29d. D	Date signed (Month	Day, Year)
	->-0		1 DoDa	2 000		D53	1306	Mi	7 19°	2005
i	771		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type,	Print)	0 0			
	10		DENN 15 - H - 2) 1E		o PHT GAD	ELIBYA	to Suite	200 6	SAUTO K	021237
	Sta		31. Date filed (Month, Day, Year)	5 2005 Registra	's Signature	Good &				
	Regist	di	201733		Carried By	3				

D-3.	246		State of Maryland / Department of Health and No. 1- State One of Ph. 343.05/24/0x16 Peath - 3-(	Mental Hy	giene	1 "7 1 / 2"
			1. Decedent's Name (First, Middle, Last)	2. Date of De.	ath	3. Time of Death
	Physici /Medio		Randolph S.D. Bertrand	MAY Month	9, 2005 Year	2345 P M
	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	1	4c. County of Death	
			ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS  5 Social Security Number 6 Sex 7. Age (in yrs. last birthday) ff Under 1 Year 1 if Under 24 Hrs.	1	ANNE ARUN	
25	Funeral Director		579-96-6842 1 M 2 F 34 Yrs. Months Days Hours Min.	8. Date of Bird (Month, Da July 5,	y, Year) Cou	place (State or Foreign intry) ington, DC
N)	and w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
	Marylan -f show fied at	ğ	MD Anne Arundel Odenton		-	1 <b>X</b> Yes 2 □ No
	vith the Maryie t or 28a-f shor be notified at	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Cou	intry?
	ath w		8700 Aspen Grove Court 21113		United St	
36	filed within 72 hours after death with the Maryland Hygiene. uthar then "natural", or Items 23a or 28a-f show ent. Ite Mcdical Examinat must be motified at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ★ Never Married 2 ★ Married  3 ★ Widowed 4 ➡ Divorced  12. Was Decedent of Hispanic Origin? (Sr ff Yes, specify Cuban, Mexican, Puerto ff Yes, Give Year or Dates:	pecify Yes or No o Rican, etc.)	- 14. Race - Ameri Black, White Specify: B]	, etc.
9	thour stural		15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/Ir	
215	be filed within 72 ho tal Hygiene. d othar than "natu event. Itse Medical	Completed	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)  Etementary/Secondary (0-12) College (1-4or 5+)	king		
2	filed wil Hygien other th	Com	2 yrs. Manager		My Eye Doct	tor
Maryland 21215-0036	g la b	Be	D 1 1 1 0 D 1		Maiden Sumame)	
Z S	d 2 should be th and Mental 7 is markad of traumatic eve	40	RONGOIPN S. Bertrand  Rose Deh  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru		or City or Town State Zi	r Code)
Ma	D		Rose Bertrand/ Mother 1920 Richie Road Fores			, 0000
J.	es 1 and 2 of Health f Itam 27 I r othar tra		cometent crematers or other place)	Date	20c. Location - City or T	own, State
imo	Pages ment of P ant: If Its ury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham Cemetery May	21,2005	Cheltenham.	Maryland.
Baltimore,	permit. Pages Depertment of Important: If It any Injury or o		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Party A Quitin 846  24. Name and Address of Facility	3821 14	the STAW	WASIDE
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory ar	rest,	Approximate Interval Between
	Physician		fmmediate Cause (Final disease or condition resulting in death)  Cardiac Arrhythmia due to Dilated C	Cardiomy	opathy	Onset and Death
	/Medical Examiner		Due to (or as a consequence of):			
\$		er	Sequentially list can diture b. Due to (or as a consequence of):			
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8760,	ate b	dicai	d			
Box 6	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and ral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of deliv	ery Day Year
P.O. I	that the de led by the a detached f	ysic	1   Yes 2   No 9   Unknown 9   Unknown			
of Vital Records, P	uires that signed b	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribute to t res 2,5No 3 ☐ Prol	the cause of death?
Ö	tw require s been si	Completed		24a. Was	an 24b. Were auto	opsy findings available ompletion of cause of
Re	The taw te has	mo			rmed?   death?	ompletion of cause of
ita	sician: The certificate hi rector, page	BeC	25. Was case referred to medical examiner?			
> <b>↓</b>	hysic this ce al dire	10	1 X Yes 2 No Hospital: X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho		lence 6 Other (Special	(y)
o uc	ding Ph h. After th funeral	lon:	27. Magner of Death  1 Phatural 5 Pending (Month, Day Year)  28a. Date of Injury (28b. Time of Injury Work?  1 No Absolute 1 Injury Work?  1 Yes 2 No	28d. Describe h	now injury occurred	
Division	Attand death ctor: , y the f	ficat	2 Accident	28f. Location (S	Street and Number or Run	al Route Number,
Div	s after s after al Dire	Certification;	28e. Place of finjury - At home, farm, street, factory, office building, etc. (Specify)	City or Tox	m, State)	
	To the Hospital or Attanding Pi within 24 hours after death. To the Funaral Director: After ti completely filled in by the funera	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due to the or rred at the time,	cause(s) and manner as s date and place, and due t	tated. o the cause(s)
	To t within To t	×	29b. Signature and title of certifier OCME		MAY 10, 2	
	10		30. Name and address of person who completed cause of death (flem 23a) (Type, Print)  111 Penn Street	Baltim	ore, Maryla	nd 21201
	Sta Registi	1	MAY 2 5 2005 32. Registrar's Signature (Month, Day, Year)			

			1 - For State Registrar		State of	Maryla	•	artment <i>rtificate</i>			and M		Reg. No.	005	71	¥63
	Physici	an	Decedent's Name (First,	Middle, Las	t)							<ol><li>Date of De Month</li></ol>	Day	Year	3. Time of D	
	/Medi		John		J.			Bake				May	19	2005	0645	М
4	Examir	ner	4a. Facility Name (If not ins	-				4b. City, T	own, or nbri		of Death			ounty of Death		
			2120 John 5. Social Security Number	6. Se			last birthday)	If Under 1		If Under:	24 Hrs.	8. Date of Bir		nne Ar		Foreian
	Funeral Director		166-14-0973		X M 2□F	92	-		Days	Hours	Min.	(Month, Da	y, Year)	Penn	place (State or intry) sylvani	a
			Usual Residence of Deced													
	show		10a. State 10b. 0	County		10c. C	ity, Town or Lo	ocation							10d. Inside City 1 ☐ Yes	
	Ba-1	ecto		nne Ar	undel		Gamb	rills					10 0111			ALA!
	with the	by Funeral Director	10e. Street and Number	. 1.	D 1			10f. Zip (		. ,				of What Co	intry?	
	eath r	erai	2120 John I	норкіп	S KOAQ 12. Was Dece	dent Ever in I	U.S. 13.		2105		gin? (Spe	ecify Yes or No	US	A Race - Amer	ican Indian.	
10	r Item	Fu	1 Never Married 2	Married	Armed For	ces? 2 🔯 No					, Puerto	ecify Yes or No Rican, etc.)		Black, White		
036	el', o	by	3 ☐ Widowed 4 ☐ Di	vorced	If Yes, Give Year or Da	tes:		1 🗆 Yes 2	No No	Specify:			Sp	ecity: W	hite	
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28a-f ehow the Medical Exartines Les notified at	Completed		ecedent's Ed	ucation de completed)		16a. Dece (Give	dent's Usual kind of work DO NOT use	Occupa done di	tion uring most	t of worki	ng	16b. Kind	of Business/I	ndustry	
121	within ne.	m pi	Elementary/Secondary (	0-12)	College (1-	4or 5+)			retired)				Do	1 4 ~ 4 ~		
	Hygie Hygie ther t		17. Father's Name (First, A	Aiddle Last)	4		PILII	ister		18. Mothe	r's Name	(First, Middle,		ligion		
anc	d be defined of ceve	To Be	Jacob Baker	_							a Re			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
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Σ	and 2 ealth a n 27 is		Patricia Pa	arker			3002	Terra	ce R	Road,	Tem	pe, AZ	85282			
ore,	of He		20a. Method of Disposition 1XXBurial 2 ☐ Crem		Removal from C	t	Place of Dispo cemetery, cre-	osition (Name matory or oth	e of ner place	)	C	ate	20c. Locat	ion - City or T	own, State	
Ë	Page nent o ent: If ury or		'4 Donation 5 □ O			Ma	nlius V	Villag	e Ce	m.	5/24,	/2005	Manl	ius, N	Y	
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than any njury or other treumatic event, Item 2006.		21. Signature of Euneral S	ervice Licen	500////	1	2:	2. Name and Harde	Address	s of Facilit Fune	ral	Home, I	P.A.			
ш	20 E 2 9		oatul.	1	Cory!			12 Ri	.dgel	ly Av	enue	, Annap	olis,	MD 21		
			23a. Part1. Enter the dis- shock, or heart failur	e. List only	one cause on ea	ch line.	ith. Do not en	ter the mode	of dying	, such as	cardiac o	r respiratory a	rest,		Approximate Interval Betwee Onset and De	∍en ∍ath
	Physician /Medical	23	Immediate Cause (Final disease or condition resulting in death)	-	a. 12.25	pir	ator	7 -	1:	7 /	un	<i>e</i>		- 1		
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	ate be executed hysician and the burial-transit	Examiner	that initiated events	1	C											
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8760,	cate b	dica			d											
9 ×	death certificate be executed e attending physician and od for use as the burial-transit	Physician/Medical	IF FEMALE:		23c. If yes, outc	ome of pregr	nancv				-		224	. Date of deliv	(0.0)	-
Вох	atten for u	cian	23b. Was decedent pregning the past 12 months	ant	1 Live bii	th 2 Fet	aldeath 3	☐Ectopic pre					230	Month	Day Ye	ar
o.	that the de led by the a detached f	isku	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unkno			, . , . , . , . , . , . , . , .	,,							
٦.	taw requires that the as been signed by th 2 should be detache	by Pi	Part II. Other significant c	onditions co	entributing to dea	ath but not re	sulting in the u	nderlying cau	use give	n in Part I.		23e. Did to	obacco use	contribute to	the cause of dea	ath?
Records,	w require been sig should b											10	/es 2□N	lo 3□Pro	bably 4 Un	known
900	has been je 2 shoul	piet										24a. Was		4b. Were aut	opsy findings av	ailable
_	The ate h page	Completed										perfo	rmed? 25 No	death?	2 No	
Vital	Physiclen: Th this certificate ral director, pag	Be	25. Was case referred to n examiner?	-	Henoutol:				1 .		of Death	(Check only o	ne)			
of	S S	2	1 ☐ Yes 2 No 27. Magner of Death		Hospital: 1 ☐ In 28a. Date of		ER/Outpaties 28b. Time o			4 [] 140	rsing Hor	ne 5 Sescribe l		Other (Speci	fy)	
	ding I	lon	Natural 5	Pending investigation	(Month	, Day Year)	Injury	M	c. Injury Work'	ai es 2⊟ì		LOU. Describe i	low injury o	ocurred		
Division	l or Attending after death. Director: After in by the fune	fica	3 Suicide 6	Could not be determined	286. Place	of Injury - At I	nome, farm, str				- 12			umber or Rui	al Route Numbe	<i>∋r</i> ,
Ď.	el or / s after I Dire d in b	Certification:	4  Homicide	deterrimied	buildin	g, etc. (Spec	ify)					City or Tov	vn, State)			
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral				sicien: To the l											
	the Hin 24 the Fi	ledical	one)		iner: On the bas		ation and/or in				in occurre					
	To Too	Σ	29b. Signature and title of	contition	641	1	~	29c.	License	number	57	42	29d. Date s	igned (Month,	G/11	
,	9		10 8	10		y		distan	W	-		7)	}	//	110)	
10	)		M.()	(101	pmpleted cause	or death (Ite	m 23a) (Typę,	1761	De	fer	150	oth	VY	Ani	ray 11	na
0	Sta	ate	31. Date filed (Month, Day,	25 20	32 <b>.</b> Re	gistrar's Sign	ature	10		7		4			11	•
	Regist		MAY	62 5	005	eur s	D. A.	Sec. of							•	

			1 - For State Registrar	State of M	aryland / De	•	t of Health a e of Death		al Hygier Reg. !	0000	171.61
	Dhysisi		1. Decedent's Name (First, Middle, Las	t)					te of Death	Day You	3. Time of Death
	Physici /Medi		Sania Bautista					Ma	y 1	$6^{\text{pay}}$ $200^{\text{pag}}$	5 <b>1</b> 0:37 P M
	Examir	ner	4a. Facility Name (If not institution, give				Town, or Location			4c. County of De	
			North Arundel Ho  5. Social Security Number 6. Se		ge (In yrs. last birtho		en Burnie			Anne Ar	
	Funeral Director			_M 2 <b>X</b> 0F	1 Yr	Months	Days Hours	Min. Fe	te of Birth onth, Day, Yea D 6 2 (	004 Ma	irthplace (State or Foreign Country) aryland
	70		Usual Residence of Decedent								
	arylan show	_	10a. State 10b. County		10c. City, Town o						10d. Inside City Limits
	8a-f.	cto	Maryland N/A		Balti						1 ☐ Yes 2 🛣 No
	with the	급	10e. Street and Number			10f. Zip				Citizen of What (	Country?
980	perinit. Tages I and Schold be littled within 72 hours ariet used if with this maryland perinent of Health and Mential Hygiene. Important: If time 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event. If a Medical Examinaria will be inclined at once.	eral	2680 Dulany St	12. Was Decedent	Ever in It S		1223	ain? (Specify Vo		5A	nerican Indian,
		Completed by Funeral Director	1 Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Forces; 1 Yes 2 2 If Yes, Give Year or Dates:	No	If Yes, spec	dent of Hispanic Ori cify Cuban, Mexicar 2 <mark>X</mark> ) No Specify:		etc.)	Black, Wh	nite, etc.
20	72 ho natur	eted	15. Decedent's Ed (Specify only highest grad	ucation	16a. D	ecedent's Usua	al Occupation	t of working	16b.	Kind of Busines	ss/Industry
21215-0036	ithin e. Mar	Jqr.	Elementary/Secondary (0-12)	College (1-4or	5+) ' <i>li</i>		rk done during mos se retired)				
2	iled w lygier her ti		17. Father's Name (First, Middle, Last)	0		N/A		al-Nama (Cina		V/A	
Maryland	ntal F ed ot ed ot	Be	Manuel A. Baut	ista				er's Name <i>(First,</i> ette Wa			
2	should od Me mark matic	2	19a. Informant's Name/Relationship (7		nd 19h M	lailing Address	(Street and Number				Zin Codel
∑	nd 2 s lith ar 27 is r trau	1 8	Bernadine Bauti	sta(Moth			Tree Dr			ie, Md.	
Baltimore,	ages 1 ar ent of Hea ht: If item 3 y or other		20a. Method of Disposition  1		20b. Place of D cometery, St. Re	isposition (Nam crematory or of St Cem	ne of ther place) letery	Date 5/24/0!		Location - City of	
21. Signature of Funeral Service Licensee  22. Name and Address of Facility ons Mort Will. Reese & Sons Mort 821 West St. Annapoli						ortuar	tuary, P.A. is, Md. 21401				
	6		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that cause one cause on each li	d the death. Do not			·			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Multi	de ini	uries					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of						
В	In law requires that the bearn certificate be executed to the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Sequentially list conditions, b. Due to (or as a consequence of):									
		nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
<u>,</u>		Examin	that initiated events c								
8760,		dical									
89		ledi		-							
O. Box		Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							23d. Date of d Month	elivery Day Year
۳.	es that tigned by		Part II. Other significant conditions co	ntributing to death b	ut not resulting in th	e underlying ca	ause given in Part I.	236	e. Did tobacco	use contribute	to the cause of death?
ecords,	quires n sigr ald be	d by							1 🗆 Yes	2 No 3 □ F	Probably 4 Unknown
Ō	aw require s been si should b	Completed							a. Was an		
æ	ate has	mo							autopsy performed?	death?	
		0	25. Was case referred to medical				26. Place	of Death (Check	Yes 2□N k only one)	lo 1 X Ye	s 2 No
<u></u>	S S	To B	examiner? 1 X Yes 2 □ No	Hospital: 1 🗌 Inpatie	ent 2 ER/Outpa	itient 3 DO	Other	rsing Home 5[		6 □Other (Sp	ecity)
			27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju (Month, Da	ry 28b. Tim y Year) Inju	e of 28	8c. Injury at Work?				
Division	endii eath. or: A the fu	catle	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury  (Month, Day Year)  28b. Time of Injury at Work?  28d. Accident investigation  5-16-05  9:58  M  1 Yes 2 KNO  with a nother meter vehicle							ruehilo	
<u> </u>	tal or Attending Pl s after death. al Director: After the ed in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm c. <i>(Specity)</i>	, street, factory,	, office	28f. Loc City	ation (Street a or Town, Sta	and Number or F ite) 5B Rt	Rural Route Number, 648 @ Rt.97
	Hospital or Attending 24 hours after death. Funeral Director: Afte tely filled in by the fune		200 Cartilla AD Cartifula Dh			tad		Fern	date	m D	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying Phy (Check only one)  1 Medical Exam	sician: To the best iner: On the basis o and manner st	f examination and/c	eath occurred a r investigation,	at the time, date and in my opinion, deal	o piace, and due th occurred at the	to the cause( e time, date a	(s) and manner a nd place, and du	is stated. re to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier			29c.	License number		29d. D	ate signed (Mor	oth, Day, Year)
	1	/	I him his	mis			OCME			May 17,	2005
ıĹ.	1	9	30. Name and address of person who c		leath (Item 23a) (Ty	pe, Print)	OG III	110-00-00-00			
4			LING LI	mis		111	Penn Str	eet Bal	timore	Marylan	nd 21201
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature						
1	Registr	ar	MAY X	5 2009	Marches A	603	AS EL				

DHMH 17 Rev 1/2001

ORIGINAL

Matthew Buck 05-03537 NJM

			For State	State of Ma		epartment of F			~ UU,	5 17465	
			Registrar Certificate of Death  1. Decedent's Name (First, Middle, Last)						Reg. No.	3. Time of Death	
	Physici		Matthew J. Buck					Month May	22 200	m	
Examiner  4a. Facility Name (If not institution, give street and number)  4b.						4b. City, Town, o	r Location of Death	1 114)	4c. County of De		
		Loch Raven and Dulaney Valley Road Timonium						Baltimore			
	Funeral Director		3/3-00-0/31	M 2 F	e (In yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month Day Oct. 10	<sup>h</sup> , <sup>Year)</sup> 9. В	irthplace (State or Foreign Country) Chigan	
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits	
	Manyi -f sho	tor	Md. Balt	imore		Cockeyswil	le			1 ☐ Yes 2 🖔 No	
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What (	Country?	
	hin 72 hours after death with the Maryland B. an "natural", or Itams 23a or 28a-f show Medical Ezzininer must be molified at	ral	10594 Blue Bel			2	1030		USA		
936		by Funeral	11. Marital Status  1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, nite, etc.  White	
Maryland 21215-0036	72	eted	15. Decedent's En (Specify only highest gra	ducation	16a. I	Decedent's Usual Occup	ation	ina	16b. Kind of Busines	s/Industry	
7	within ene. than "u	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Give kind of work done of life. DO NOT use retired		9			
2	77		17. Father's Name (First, Middle, Last,		AS	sistant Sup		e (First Middle	Landscap	ing	
and	D # D &	o Be	John E. E					inda M. Delugas			
ary	2 should and Men is marka raumatic	-	19a. Informant's Name/Relationship (		19b.	Mailing Address (Street				, Zip Code)	
	is 1 and 2 should of Health and Mer itam 27 is marke other traumatic		Mr. John E. Buck/F	ather	105	94 Blue Bel	1 Way Co	ckeysvi	lle, Maryl	and 21030	
altimore,	of He of He if itam		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of cemetery	Disposition (Name of , crematory or other place	ce)	Date	20c. Location - City of	or Town, State	
Ë	. Pag tment tant: jury c		* 4 ☐ Donation 5 ☐ Other (Specif	y)	Dulaney	Valley Mem					
Bal	permit. Pages 1 Department of H Important: If its any injury or ot once.		21. Signature of Funeral Service Lice	1 Rus		1050 York	Road To	wson, M	aryland 21	Home, Inc. 204	
			23a. Part1. Enter the disease, or constance, or heart failure. List only	plications that caused one cause on each lin	the death. Do no	ot enter the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death	
	Physician	K N	Immediate Cause (Final disease or condition resulting in death)  a								
	/Medical Examiner		Toolaning in double,	Due to (or as	a consequence o	): 0					
		Iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
	uted d ansit	mlm	Cause (Disease or injury that initiated events	C							
0	icate be executed physician and s the burial-transit	Exam	resulting in death) Last	Due to (or as	a consequence o	·):					
8760,	ate be	dlcal		_ d							
9	eath certific attending p I for use as	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				22d Date of d	oliston	
Вох	atten atten	hysician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	1		23d. Date of d Month	Day Year	
Ö.	that the de led by the a detached	hysl	1  Yes 2  No 9  Unknown	9□ Unknown		_ ,, ,,					
S, D	es tha igned l be det	by P	Part II. Other significant conditions of	contributing to death be	ut not resulting in	the underlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?	
ord	w require been sig should t							1 🗆 Y	'es 2 No 3 1	Probably 4 □Unknown	
O E S O Q								sy prior to	24b. Were autopsy findings available prior to completion of cause of		
a H	ian: The rtificate ha	O							med? death? 2☐ No 1 XYe	s 2□No	
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ★ Yes 2 □ No	Hospital: 1 Innatia	nt 2 - ED/O	oth Oth	er: 4 Nursing Ho			100/hi 5/ 6 5 6	
10		$\vdash$	TE impatient 2 Envolupation 3 DOA 4 Invising Notice 5 Residence 6 Apoline (Specify)								
ioi		atlo	1 Natural 5 Pending Committee Self Injury Mark? Injury Subject Shot Self								
Division		Certification:	3 Suicide 6 ☐ Could not be determined		ury - At home, fari	n, street, factory, office		28f. Location (S City or Tow	treet and Number or I m, State)	Rural Route Number	
Ω	urs af urs af aral D	_			· · · · · · · · · · · · · · · · · · ·	mood2		ROS I	THE STA	L'A	
	a Hospital 24 hours a Funaral etely filled	edica	29a. Certifier 1 Certifying Pl (Check only 2 Medical Exal	nysician: To the best of miner: On the basis of and manner sta	ot my knowledge, examination and ited.	death occurred at the tin or investigation, in my o	ne, date and place, pinion, death occuri	and due to the o red at the time, o	cause(s) and manner : date and place, and di	as stated. ue to the cause(s)	
	To the Hospital or within 24 hours after To the Funaral Discompletely filled in	Me	29b. Signature and title of certifier		$\bigcirc$	29c. Licens	e number	2	29d. Date signed (Moi	nth, Day, Year)	
	10	2/	PRT : (10	onice-	Tolleh	~~   OCI	ALL STATES		May, 23,	2005	
6	1		30. Name and address of person who	completed cause of d	path (Item 23a) (T		onn Ctran-	+ Dal+		10000	
1			PATRICIA A	ronice -	Tollak	W) III Pe	enn Stree	L Balt:	unore, Mar	yland 21201	
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature						
DHI	MH 17 Rev 1/2		MAY 2 5 20	General	1. K. K.	carle					
					ORIG	INAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 23 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore JOHNS HOPKINS HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month | Days | Month | Days | Month | Days | Month | Days | Month | Month | Days | Month | Month | Month | Month | Days | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign
 Country) **Funeral** 1 □ M 2 F Yrs. 216-32-6158 Usual Residence of Decedent Director with the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits ehow 27 is marked other than "naturel", or items 23e or 28a-f ehov treumetic event, it a Madical Exercit et r. ust be redified at 1 Pes 2 □ No timore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24 SA death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ont: If item 27 is marked other than "naturel", or Item 1 ☐ Never Married 2 ☐ Married 1□ Yes 2 Xo Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) r's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Importent: If item 27 is any injury or other treu 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee leur 2 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner REGURGITATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 5 Other (specify) ed by the a detached for 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed been 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No this certificate has ral director, page 2 2 No 1 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: ၉ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai ompletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registra

Registrar's Signature

600 NORTH WOLFE STREET BALTIMORE, MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALLAR BHATTACHARYA

MALLAN
31. Date filed (Month, Day, Year)

			For State Ragistrar	State of Maryland / Depa	artment of Health and N rtificate of Death	fental Hygie Rag.	15 15 11 -	\$ none \$ and accept		
	Physici		1. Decedent's Name (First, Middle, Last)			2. Date of Death	Day O'S	3. Time of Death		
	/Medic Examir Funeral		4a. Facility Name (If ket institution, gives) 5. Social Security Number 6. Sex	Onewood  7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death  Graph Color of Colo	8. Date of Birth (Month, Day, Ye	4c. County of Death	A lace (State or Foreign		
	Director		243 - 21 - 1450 1□ Usual Residence of Decedent  10a, State 10b, County	M 220 F 66 Yrs.		June 7,	1938 5.	Od. Inside City Limits		
altimore, Maryland 2	he Maryia 188-f ehov	ector	Maryland N/A		more			1∆Yes 2□No		
	iges 1 and 2 should be ilied within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other than "natural", or Itema 23a or 28a-f ehow or other fraumatic event, it a Madical Examiner must be notified at	Funeral Director	10e. Street and Number 401 25th Street	///	10f. Zip Code 2/2/8		Citizen of What Coun			
			11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?	Was Decedent of Hispanic Origin? (Sp if Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	etc.		
	ed within 72 h ygiene. ner than "natu t, It e Medical	Completed by	15. Decedent's Educ (Specify only highest grade	completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16b	Own H	,		
	ould be fited Mental Hygi arkad other atic event, II	To Be C	17. Father's Name (First, Middle, Last) BOO S L	ee	18. Mother's Nam	e (First, Middle, Maid	den Sumame)			
	es 1 and 2 sho of Health and ! f Item 27 Is ma r other traums		19a. Informant's Name/Relationship (Type)  19a. Informant's Name/Relationship (Type)  19a. Informant's Name/Relationship (Type)  10a. Method of Disposition  10a. Informant's Name/Relationship (Type)  20a. Method of Disposition  10a. Informant's Name/Relationship (Type)  20a. Method of Disposition  10a. Informant's Name/Relationship (Type)  20a. Method of Disposition  10a. Informant's Name/Relationship (Type)  20a. Method of Disposition  10a. Informant's Name/Relationship (Type)  20a. Method of Disposition  10a. Informant's Name/Relationship (Type)  20a. Method of Disposition  10a. Informant's Name/Relationship (Type)  20a. Method of Disposition  10a. Informant's Name/Relationship (Type)  20a. Method of Disposition  10a. Informant's Name/Relationship (Type)  20a. Method of Disposition  20a. Method of Disposition	hoi (Son) 8057	natory or other place)	Date 200	Location - City or To	MD, 21661 wn, State 1		
	permit. Pages Department of Important: If It any Injury or o		'4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	Dulaney V	2. Name and Address of Facility	tives Fun	Timonium, veral + Cr	emition (to		
Records, P.O. Box 68760,	Ase executed yes like the second of the purial-transit transit	23a. Patri. Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faillure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
	that the death certifice ted by the attending phedeted for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year		
	requires een sigr	by	Part II. Dther significent conditions con	tributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacc 1 ☐ Yes		ably 4 luknown		
	The lay ate has page 2	Completed				autopsy performed	prior to con death?	osy findings available inpletion of cause of		
f Vital	d is	To Be	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{No} \)	ospital: 1   Inpatient 2   ER/Outpatien	Othor	h (Check only one) me 5 🗆 Residence	e 6 □Other (Specify	)		
Division of	ding After fune		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	f 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how in	njury occurred			
		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	t and Number or Rura tate)	Route Number,		
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edical	29a. Certifier (Check only one)  Certifying Physical Examination  (Check only one)	ician: To the best of my knowledge, death er: On the basis of examination and/or in- and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as stand place, and due to	ated. the cause(s)		
),	To the within 2 To the complete	M	29b. Signature and title of certifier	Blad Mirra W	D LIGON		Date signed (Month, I			
1	10		5601 lock	mpleted cause of death (Item 23a) (Type,	MV Onte and	10 5	1239			
	Sta Regist		31. Date filed (Month, Day, Year) 2 5	2005 <sup>22. Registrar's Signature</sup>	posti					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year 19 2005 9:57am<sup>M</sup> May Evelyn Lillian Case 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 X F Yrs. 278-14-3034 83 07/11/1921 Kentucky Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No MD Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21078 USA 303 Commerce Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Gustav Miller Marie (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 303 Commerce St., Havre de Grace, MD 21078 Sheryl Speerstra- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) R.A. Ferris & Co. 05/20/05 West Chester, PA 21. Signature of Funeral Service Licensee Mitchell-Smith Funeral Home, P.A. Maire 123 S. Washington, Havre de Grace, MD 21078 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTIL Shock Due to (or as a consequence of): 4 days er forATED Sequentially list conditions, if any, leading to immediate cause. E. tor Ur Jan in g Cause (Disease or injury Due to (or as a consequence of): Colm GANGEL UNKNOWN that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Who 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 2 X No 25. Was case referred to medical examiner? 1 Tes 2 Alo 26. Place of Death (Check only one) Hospital: 1 Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) 5/19/05

Division of Vital Records, P.O. completely filled in by the funeral

Physician

/Medical

Examiner

Director

by Funerai

Completed

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Certification: To

Medicai

3 Suicide

29a. Certifier

4 Homicide

**Funeral** 

Director

Hygiene. other than "natural", or Items 23a or 28a-f show rent. Itte Medical Exame activital be collified at

Baltimore, Maryland 21215-0036

5/19/05

12 should be filed w h and Mental Hygier 7 Is marked other th

permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked any injury or other traumatic evone.

Physician /Medical

**Examiner** 

within 24 hours a

State Registrar

Delut md 30 Name and address of person woo completed cause of death (Item 23a) (Type, Print) AnTomette Sperdiz

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

501 5 Union

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) MAY 2 5 2005

DHMH 17 Rev 1/2001

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DHMH 17 Rev 1/2001

Registrar

			1 = For State Registrar	State of Maryland / Dep Ce	eartment of Health and ertificate of Death		ene 9. No 2 0 0 5	17471
	Physici /Medio		1. Decedent's Name (First, Middle, Last)	ELIZABETH	DICKERSON	2. Date of Death Month	Day 2005	3. Time of Death 8:45 P M
- Single	Examin Funeral	400	4a. Facility Name (If not institution, give s 5707 PLAN FIE 5. Social Security Number 6. Sex	17. Age (In yrs. last birthday		RE	4c. County of Death	place (State or Foreign
	Director		Z11·22·4412 1□ Usual Residence of Decedent	M 2/2 F 77 Yrs.	Months Days Hours Mir	8. Date of Birth (Month, Day, )	1928 HEN	NSYLVANIA
	e-f ehow	ctor	10a. State 10b. County	10c. City, Town or L	ocation TIMORE			10d. Inside City Limits 1 LYes 2 □ No
	th with the 23s or 28	Funeral Director	5707 PLAINT	TIELD AVE.	10f. Zip Code 2/20	06	g. Citizen of What Cou	.A.
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23e or 28e-1 ehow appringuty or other traumatic event, ite Medical Erachina Intelligible at an ance.	þ	11. Marital Status  1 M Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Pver in U.S. Armed Forces  1	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☐ No Specify:	Specify Yes or No- into Rican, etc.)	14. Race - Ameri Black, White, Specify:	
21215-0036	within 72 hound. Then "neture The Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary(Secondary (0-12)	completed) (Give	edent's Usual Occupation e kind of work done during most of w DO NOT use retired)  LABORER	orking 16	6b, Kind of Business/Ir	
	e filed value of Hygie other t	Be Co	17. Father's Name (First, Middle, Last)		18. Mother's Na	ame (First, Middle, Ma	aiden Sumame)	
Maryland	should be nd Mental r marked c	10	VETEK DIK 19a. Informant's Name/Relationship (Type	CKER SON 19h Mail	ling Address (Street and Number or F	<i>M</i> (1)	CIST	in Code)
	1 and 2 s Health an em 27 is r ther traur		ANNA L. SCOH	(DAVEHTER) 570	7 PLAINTIELD	AVE. Br	JIMOKE,	1021206
Baltimore,	permit, Pages 1 an Department of Heal Importent: if item 2 any injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R. 1 ☑ Donation 5 ☐ Other (Specify)	emoval from State 20b. Place of Disp cemetery, cre ARBUTUS	osition (Name of malory or other place)  CEMETERY  2. Name and Address of Facility		Oc. Location - City or T	
Balt	permit. Departr Importa any inj		21. Signature of Funeral Service License		2. Name and Address of Facility	AUGHN C	MARE MAR	FUNERAL HM (LAND 21212
	Physician /Medical Examiner		23a. Part1. Enter the disease, of complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of)		ac or respiratory arres	it,	Approximate Interval Between Onset and Death
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Division of Vital Records,	The law requir cate has been si page 2 should	Completed				24a. Was an autopsy performe	prior to co death?	opsy findings available ompletion of cause of
Vita	ysician: The is certificate hadirector, page	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1   Inpatient 2   ER/Outpatie	Othor	Home 5 Residen	ce 6 ⊟Other (Specia	ifv)
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	ne Hoepite	edical C	(Check only 2 Martical Evamin	icien: To the best of my knowledge, dea her: On the basis of examination and/or in and manner stated.	properties tion in my opinion, death occ	surrord at the time date	a and place, and due t	to the cause/e)
)	To the within To the comp	Me	29b. Signature and title of certifier  2 Av M	mpleted cause of death (Item 23a) (Type 32. Registrar's Signature	29c. License number	290	Date signed (Month, Nay 23,	Day, Year) 2005
	51		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type	Print)   Eutaw St Ba	Himore	MD 212	0)
	Sta Registr	100	31. Date filed (Month, Day, Year) / MAY 2 5 2	32. Registrar's Signature	Spenk)			

Alene Dickerson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#28a, perME, G843, 5/25/05 11
State of Maryland / Department of Health and Mental Hygiene | | | | | | |

			1 - For State Registrar	State o	r Maryl	and 7 Dep Ce	artment rtificate	of He of C	ealth a Death	and M		gien Reg. N	-	74	72
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			500D SAMARITAN HO 5. Social Security Number	SPITAL 6. Sex	7 Age (In v	rs. last birthday)		TIMOI	KE If Under:	24 Hrs.	8. Date of Bir	rth	N/A	irthplace (State o	. Can in
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			For State Registrar		State	of Mary	/land / [		ment of F			Mental Hy	/giene Reg. No.	200	51 ee	1 mg 1 mg ,~
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	Physicia /Medic			eth_Ell								Mar	y 23	3 20	105	4:05PM
	Examin	er	4a. Facility Name (	If not institution,	give street and n	umber) - Ru (	Line		b. City, Town, o			it.	4c.	County of De	eath	
۵ ▮			5. Social Security N	Vumber	6. Sex	7. Age (/	n yrs. last bii		Under 1 Year	MIN If Unde	r 24 Hrs.	8. Date of B	irth	9. B	lirthplac	e (State or Foreign
3	Funeral Director		040-46-1		1 M 2 □ F	54		Yrs.	lonths Days	Hours	Min.	(Month, D	ay, Year)		Country	PA
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ı			23a. Part1. Enter shock, or her	the disease, or an failure. List	complications that only one cause on	caused the	e death. Do	not enter t	he mode of dyir	ng, such a	is cardiac	or respiratory	arrest.		l In	pproximate Iterval Between Inset and Death
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	/Medical Examiner		resulting in death)	)	Due	o (o sac	onsequence	of):		0	)				1	20.5
w		<u></u>	Sequentially list of	onditions,	b. Dua to	o (or as a c	ons uence	of:						16	-	augs
€	uted 1 Insit	Examiner	cause. Enter Und Cause (Disease of that initiated event	lerlying ir injury		act	icA	710	OSIA	1M	ota	bolic	ATIC	1050	(	otdays
OG	be executed ician and burial-transit	Exa	resulting in death)	Last	Due to	o (or as a c	onsequence	of):		/	~1	oone.	<del>/ \C(</del>			1 = 6
19 09 Z	te be ex sysician he buria	icai			d	xen	yda	tru	<u> </u>						1	IWEEK
文 39 xo	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transli	n/Med	IF FEMALE: 23b. Was deceded		23c. If yes, o		pregnancy Fetal death	 3□Fc	etopic pregnanc				2	23d. Date of		
T. 0.	that the deatt ed by the atte detached for	Physician/Me	in the past 12 1 ☐ Yes 2 9 ☐ Unknow	□No		gnant at tin			ther (specify)					Month	D:	ay Year
S,	ires that signed b d be deta	by Pł	Part II. Other sign	ificant conditio	ns contributing to	death but r	not resulting	n the unde	erlying cause gr	on in Par	t 1.	1	tobacco u	a.P		cause of death?
oro	w requii been s should	Completed by	HOUN	OIA	NISC									1		
Jec	e law has b	mpi										24a. Wa aut	opsy formed2	prior t death	o comp	y findings available eletion of cause of
a	ician: Th certificate rector, pag		OF Was seen rain	ered to modical						00 DI-	1 D	1 ☐ Yes	2 X No	1 🗆 Y	es 2	No
Z.	ysician: The is certificate his director, page	o Be	25. Was case reference examiner?	vied to medical No	Hospital:	Inpatient	2 ER/0	utpatient	3 DOA Ott	105		th <i>(Check only</i> ome 5 ☐ Res		S∏Other (S	pecify)	
ō	ding Phys h. After this funeral di	n: To	27. Manner of Dea	ath	28a. Dat	e of Injury onth, Day Y	28b.	Time of	28c. Inju			28d. Describe			, ,	
<u></u>	ttending F death. stor: After the funer	atio	Natural 2 Accident	5 Pending	ation	min, bay i	our,	injury		Yes 2[	□No					
Division of Vital Records,	after de Directo	Certification:	3 Suicide 4 Homicide	6 ☐ Could r determ	288. Pia	ce of Injury Iding, etc. (	- At home, f 'Specify)	am, street	, factory, office				(Street an own, State		Rural F	Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	dical C	29a. Certifier (Check only one)		g Physician: To to Examiner: On the and ma		camination at									
	within 2	2 Pe	29b. Signature an	title of certifier					29c. Licens	se numbe	r		29d. Dat	e signed (Mo	onth, Da	ıy, Year)
				X	$\times$	ID	O		128	ES-	-20	GC	M	aus 2	3.	2005
	0		30. Name and add	dress of person	who completed ca	use of dea	th (Item 23a)	(Туре, Рг	int)	^	A 4-	nove		()	1	
_	V		toethy	y-War	VA, DD	Sm	a th	1980	re of	, He	Whi	nne				
	Sta Regist		31. Date filed (Mo	nth, Day, Year) ΔΥ $252$	005	Registrar's	Signature	best								

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	Examir		4a. Fecility Name (If not institution, JHH					Ltimo	ocation of Dre If Under 2			4	c. County of Dea		
	Funeral Director		5. Social Security Number 237-38-2684  Usual Residence of Decedent	6. Sex 1 □ M 2 🖾 F	7. Age (in yr.	s. last birthday) Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da 8 4	y, Yea		rthplece (State ountry) N.C.	or Foreign
	se Maryland	Director	MD 10b. County	Ą	10c. (	Baltim									ity Limits
0036	i within 72 hours after death with the Maryland liene r than "natural", or Items 23a or 28a-1 show the Medictal Examinar must be notified at	by Funeral	104.7 N. Kenwo 1. Marital Status 1 Never Married 20 Marrie 3 Widowed 4 Divorced	12. Was Dece Armed Fo	ident Ever in rces? 2017 No	ì		21205 ent of His fy Cuban		in? (Spe Puerto f	cify Yes or No Rican, etc.)	207	USA  14. Race - Am Black, Whi  Specify: B	erican Indian,	
1215-	within ene. than	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 10th		-4or 5+)	(Give	dent's Usual kind of work DO NOT use sembly	done du retired)	ring most	of workir	ng .		Kind of Business Jestingh	ŕ	
Maryland 21215-0036	be filed stal Hyg ed othe event,	To Be Co	17. Father's Name (First, Middle, L Emmitt	·	Perry				18. Mother	's Name (labe)	(First, Middle,			<u> </u>	
	nd 2 shouth and 27 is m		19a. Informant's Name/Relationsh Cleophas Eaton-			1047	N. Ke	nwoc		enue	Baltim		or Town, State,	Zip Code) 21205	
Baltimore,	0 0		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp	ecify)	D1-1-	Place of Dispo cometery, crea Garden	matory or oth of Fai	er place th	5	5/26/	/2005		Location - City or ltimore		MD
Ball	permit. Page Department Important: It any injury o		21. Signature of Funeral Service L	, wa	ne			. No	rth A	MAF Vent	<u>le Balt</u>	imo	L HOME-1 re, MD	21202	
	Physician /Medical Examiner		23a. Par11. Enter the disease, or i shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nly one cause on e	ach line.	DIOVA								Approximat Interval Bet Onset and	ween
8760,	ate be executed sysician and he burial-fransit	icai Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conse										
P.O. Box 68	the death certifica y the attending ph ched for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 25d No 9 ☐ Unknown		irth 2 ☐ Fe ant at time of	tal death 3[	□Ectopic preç □ Other (spec						23d. Date of de Month		Year
	es pe	þ	Part II. Other significant condition	ns contributing to de	ath but not re	esulting in the u	nderlying cau	use giver	in Part I.		23e. Did to	- (	use contribute to	o the cause of corobably 4 🗆	
Division of Vital Records,	The ate h page	Completed									24a. Was autop perfor 1 Yes	sy rmed?	prior to death?	utopsy findings completion of c	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		J		Other			(Check only o		-1,-		
on of	iding Phys th. After this funeral di	tion: To	1 Yes 2 No  27. Manner of leath Natural 5 Pending Accident investig	28a. Date o		28b. Time o Injury		c. Injury a Work?	4 🗀 Nurs	2	e 5 Resid		6 ☐Other (Spe iry occurred	cify)	
Divisi	To the Hospital or Attending Physical within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral directors.	Certification:	3 Suicide 6 Could n 4 Homicide determin	ot be 28e. Place	of Injury - At ng, etc. (Spec	home, farm, str	eet, factory,	_			8f. Location (S City or Tow		nd Number or R e)	ural Route Num	ber,
	To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b	edical (	29a. Certifier   Control	Physician. To the xaminer: On the ba and mann	isis of examin	lowledge, death	vestigation, in	n my opir	, date and nion, death	piace, ai occurre	nd due to trie d d at the time, d	ause(s date an	s) and manner as id place, and due	stated. to the cause(s	)
,	To Within	Σ	29b. Signature and title of certifier	A 61				License		57			ate signed (Mont		
	Sta Registr		30. Name and address of person with the control of	ala di		em 23a) (Type,	Point)	Da-	. ha	Eve	te I	6	5/24/ wsow	ND 21	204

State of Maryland / Department of Health and Mental Hygiene 2005 For Stata Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 2005 May 2210 12 Dorothy Stilwell Eddington /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Harford 4141 U Way Havre de Grace If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1□M 2**X**F Yrs. 01/14/1921 Pennsylvania 164-18-6888 84 Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or iteme 23s or 28s-f show any injury or other traumatic event, if a Medical Examinal must be notified at Ancel 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No Directo Harford Havre de Grace MD 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number USA 4141 U Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government 12th Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clarence Stilwell Sarah Brown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4141 U Way, Havre de Grace, MD 21078 Vernon Eddington- Husband Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Harford Mem. Grdns. 05/17/05 Aberdeen, MD Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, 21. Signature of Funeral Service Licenses Munh MD 21078 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myochunin memotion **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dewlehsion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last to (or as a consequence of) Examiner Molitus The law requires that the death certificate be executed burial-transit DIPHETU and Due to (or as a consequence of): ed by the attending physician detached for use as the buria OSTEV Antimitis Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed?

1 Yes 2 No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? or Attending 5 Pending investigation 1 Yes 2 No within 24 hours after death. To the Funerel Director: A 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospitel 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one To the ! 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 13/05 1746412 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOTE Mn 31. Date filed (Month, MNION Day, Year) 2. Registrar's Signature State 2 5 2005 Registrar

			For State Registrar	State of Ma	aryland / D	epa <i>Cer</i>	rtment of H	lealth a Death	and Me	ental Hy	ygiene Reg. No	-	05	174	76
			1. Decedent's Name (First, Middle, La	ist)					- 7	2. Date of D	eath			3. Time of Deat	
	Physici /Medio		Almore Jackson	Emery						Month MAY	( O		Year	6:450	М
	Examir		4a. Facility Name (If not institution, gi				4b. City, Town, or	Location o			40	. County o		-	
			Union Memorial H				Baltimor				N	I/A_			
	Funeral Director		127-18-7115	Sex 7. Ag 1 M 2 F 7	e (In yrs. last birtl	rs.	If Under 1 Year Months Days	If Under 2 Hours		B. Date of B (Month, D arch	irth Pay, Year 22,	1926	9. Birthpi Coun: New	ace (State or Fore try) York	ə <i>ig</i> n
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Loc	ation						10	Od. Inside City Lin	nite
	Manyl f sho	ō	MD Baltimo	re	Baltimo								'	1 ☐ Yes 2 🛣	
	28a	rect	10e. Street and Number		1		10f. Zip Code				10a. Ci	tizen of Wi	nat Coun	trv?	
	h with	O IE	807 Chumleigh Ro	ad			21212				USA			,	
	deat	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. W	Vas Decedent of Hi Yes, specify Cubai	spanic Orig	in? (Spec	ify Yes or N		14. Race			
92	or It	by Funeral Director	1 Never Married 2 Married	1 XYes 2 1	No			Specify:	, ruento m	icari, etc.)		Specify:	, White, e ساء wh		
Ö	thours	q pa	3 XWidowed 4 Divorced	Year or Dates:	1 40.										
5	in 72	Completed	15. Decedent's E (Specify only highest gr	ade completed)		(Give k	ent's Usual Occupa and of work done d ONOT use retired,	<i>lurina</i> most	of working	7	16b. K	and of Bus	iness/Ind	ustry	
212	with Jiene.	om	Elementary/Secondary (0-12)	College (1-4or 5	5+)		tant	,			In	suran	ice		
פ	othe vent,	BeC	17. Father's Name (First, Middle, Las.	)				18. Mother	r's Name (	First, Middle					
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland ind Mental Hygene. Ind Mental Hygene s marked other then "naturel" or Items 23e or 28e-1 show umatic event, The Medical Examiner must be notified at	Tof	Almore Jackson	Emery					abeth		riet		ner		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "naturel; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship Melissa G. Eme	ry / daugh	ter 1	Chi	anney Hear	n <i>d Numbei</i> rth Co	r or Rural I Ourt;	Route Numb Balt	i mor	o <i>rTown,S</i> e, MD	tate, Zip 212	Code) 34	
Baltimore,	as 1 a of Hez	-	20a. Method of Disposition	¬¬¬¬¬	20b. Place of cemetery	Dispos	ition (Name of atory or other place	9)	Dat	te	20c. L	ocation - C	ity or Tov	wn, State	
Ĕ	permit. Pagas Department of H Importent: If Ite any injury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Speci	wentombment	Dulaney	Va11	ley Mem Gar	dens 5	/26/0	15	Tim	onium	, MD		
<u>a</u>	Depart Depart Import any inj once		21. Signature Funeral Service Lice	nsee			Name and Addres	,				050 Y			
	40 E 8 9		1 cth U	My			ck Towson					owson	, MD	21204	
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	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Acut		100	my Sy	ndre	ime	l.				Onset and Death	w
	/Medical Examiner		Todaling in dealing		a consequence of	f):		)						8	_
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter indexlying Cause (Disease or injury that initiated events	Coron	0		di	Scase						18/11/18	5
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8760	ate be hysici ihe bu	dicai		_ d.											
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Вох	eath certific sttending p for use as	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		Ectopic pregnancy					23d. Date Month		y Day Year	
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J.	res that ignad b	by Pr	Part II. Other significant conditions	contributing to death be	ut not resulting in t	the und	derlying cause give	n in Part I.		23e. Did	tobacco i	use contrib	ute to the	cause of death?	
Records,	w requires been sign should be	ed b								1 🗆	Yes 2	<b>Z</b> No 3	Proba	bly 4 🗆 Unknow	wn
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Vital	iicien: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?					26. Place	of Death	Check on					
<u></u>	Physic this or	2	1 ☐ Yes 2 ☑ No	Hospital: 1 npatie			3 DOA Other	r: 4 🗌 Nur:		5 🗆 Resi					
Division of	ding F h. Aftar funer	ion	27. Manner of Death  1. ✓ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 28b. Tir Inj	me of jury	28c, Injury Work' M 1 7			d. Describe	how injur	y occurred	1		
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2	al or A efter I Direct d in by	Certification:	4 Homicide determined	building, etc	. (Specify)	., 51.00	ot, radiory, ornos			City or To	wn, State	)	or riurar	noale Namber,	
	pspital hours e unerel y filled		29a. Certifier 12 Certifying Pl	nysicien: To the best of	of my knowledge,	death	occurred at the time	e, date and	l place, and	d due to the	cause(s)	and mann	ier as sta	ted,	
	To the Hospital or Attanding Physicien: within 24 hours eiter dealt within 24 hours eiter dealt  To the Funerel Director: Altar this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical Example)	miner: On the basis of and manner sta	examination and/	or inve	estigation, in my opi	inion, death	n occurred	at the time,	date and	place, and	d due to t	he cause(s)	
	To the within 2 To the comple	Σ	29b. Signature and title of certifier				29c. License					te signed (		-	
	1	7/	1 Am	M.D.			AT - 2	438	946-	E13	Wb	1. 4	9,2	5002	
C	XX		30. Name and address of person who				,							n. n. n	
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	Registr	ar	31. Date filed (Month, Day, Year). MAY 25 2	005	ar's Signature	900	A SEP								

			1 - For State Registrar	State of M	aryland /		artment <i>tificate</i>			nd M		ene (	15	17477
			1. Decedent's Name (First, Middle, Last)								2. Date of Death		Vara	3. Time of Death
	Physici /Media		HAROLD				ESSI	GMA N			MAY 23	3 200	Year 15	9:40 A M
	Examir		4a. Facility Name (If not institution, give si	reet and number)	)		4b. City,	Town, or l	Location of	Death		4c. County	of Death	
	-		SINAI HOSPITAL						BALTI					N/A
	Funeral		5. Social Security Number 6. Sex 1 🖄	7. Ag M 2□F	ge (In yrs. last i 91	Yrs.	If Under Months	Days Days	If Under 2 Hours	Min.	8. Date of Birth 09/18/1	Yearb	9. Birthp	N.Y.
T. E.	Director		Usual Residence of Decedent		91	173.					09/10/1	913		14.1.
	yland		10a. State 10b. County		10c. City, To	own or Lo	cation						1	0d. Inside City Limits
	Mar B-f et	tor	MD BALTIMORE		BALT]	MORE								1 ☐ Yes 2 No
	th the or 28	irec	10e. Street and Number				10f. Zip	Code			10	g. Citizen of V	Vhat Cour	ntry?
	23a 23a	ral	48 FARMHOUSE COU	RT			212	208				U.S	.A.	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23s or 28s-f show other traumatic event, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Armed Forces? 1 NYes 2 I If Yes, Give Year or Dates:	No WW II		Vas Decede f Yes, speci D Yes 2	V	panic Orig , Mexican, Specify:	in? (Spe Puerto	ecrly Yes or No- Rican, etc.)		k, White,	
5-0	72 ho natur lisal	Completed	15. Decedent's Educ (Specify only highest grade	ation	16	a. Deced	lent's Usua kind of won	Occupat	tion	of worki	1	6b. Kind of Bu	siness/Inc	dustry
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Mar	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Typ		- 15						I Route Number, BALTIMOR			
	1 and Health em 27 Ather tr		JOAN ESSIGMAN / WI 20a. Method of Disposition	r E	20b. Place				COOK	_		Oc. Location -		
nor	Pages net of int: If it		1 ☐ Burial 2 🛣 Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State		tery, сгеп	ERVIC	her place,			. 1	TOWSON		, otako
Baltimore,		3	21. Signature of Funeral Service License	01	11	-	. Name and							TNO
ä	permit. Departr Importa		Death 71	with	Un		3900 F			20	L LEVINS ROAD - P	ON % BI		MD 21208
	A		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that cause	d the death. De									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		1/	740 V	1a,	01	ماريه					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequenc	e of):	, ~	a						
	Examiner	_	Sequentially list conditions, b.		PNE		na						2	ym
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	6 01):	ten o	10	gant	x C	dest	2	2	46
	cate be executed physician and the burial-transit	хап	that initiated events c. resulting in death) Last	Due to (or as	a copeequenc	e <b>9</b> 1):		1	F		1 1			
8760,	siciar siciar burii	dical			Cere	lso	vano	rlu	a	cel	dest			2.5 MOS.
9	g phy as the		0.											
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	Physiclan/Me	in the past 12 months?	c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal dea		Ectopic pre					23d. Date Mor	of delive	ry Day Year
o	the d by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown										
S, D	ires that signed b d be deta	by PI	Part II. Other significant conditions cont	ibuting to death b	out not resulting	in the un	derlying ca	use given	in Part I.	,	23e. Did toba	icco use contr	bute to th	e cause of death?
g	w require been sig should b	ed b	Sick SiNUS S	ynda	we u	nth	pa	cen	nap	a -	1 ☐ Yes	2 🗆 No	3 Prob	ably 4 Unknown
Record	aw requas been 2 should	Completed		,			ι				24a. Was an	24b. V	/ere autor	osy findings available
_	The lav	E O									autopsy perform 1 Tes 2d	ed?	rior to cor eath? Yes	npletion of cause of
Vita	77 —	Be C	25. Was case referred to medical						26. Place	of Death	Check onl one			22.110
	Physic this ce al dire	101	examiner? 1 ☐ Yes 2 ☑ No	spital: 1 Impatio	ent 2 ER/0	Dutpatient	3 DO	Other	4 □ Nur	sing Hor	ne 5 Residen	ce 6 Othe	r (Specify	)
0	ding Pl h. After ti funera	on:	27. Manner Death 1	28a. Date of Inju (Month, Da	iry 28b	. Time of Injury	28	lc. Injury a Work?	at	2	8d. Describe how	injury occurre	ed	
Sio	Attending Physician: r death. ector: After this certific by the funeral director.	catl	2 Accident Investigation 3 Suicide 6 Could not be				М		es 2 □ N	-				
Division of	l or Attendater death Director: I in by the	Certification:	4 ☐ Homicide determined	28e. Place of Inj building, et	lury - At home, ic. (Specify)	tarm, stre	et, factory,	office		2	28f. Location (Stre City or Town,		r or Rura	Route Number,
السا	To the Hospital or Attending Physician: within 24 hours after death. To tha Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Physic	cian: To the heet	of my knowled	de, death	Occurred o	t the time	date and	nlace a	and due to the se-	reale) and ma-	ner 22 ct	ated
	e Hos 24 h a Fur letely	Medical	(Check only 2 Medical Examinations)	r: On the basis of and manner st	it examination a	and/or inv	estigation,	in my opir	nion, death	occurre	ed at the time, dat	e and place, a	nd due to	the cause(s)
	To the Hospita within 24 hours To tha Funeral completely filled	Me	29b. Signatur, and title of contified	101		0	290	cense	number	0	296	d. Date signed	(Month, L	Day, Year)
•	1		Merbert year	1 Oste	~ m	· U	1.0	1-1	60	40		5/23/0	5	
6	2		30. Name and address of portion who con	opleted cause of co	death (Item 23a	(Type, F	Print)		1.	1	1.6	HIO	10	~ O
	y		Herbert GRI-14			Ola	1600	~ ≠ ~	121	10	4010 1	19 2	120	10
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 5 2005	Sz. Hegistr	ar's Signature	Loca	de la							

			Please	e Type or Pri							•		egible.	
			1 - For Stata Ragistrar		ar y tarre		rtificat					Rag. No.	005	171.72
П	,	<u>.</u>	1. Decedent's Name (First, Middle, L								2. Date of D		Year	3. Time of Death
	Physici /Medic		George Jam	es Fitzg	erald						05	20	200	C - / (1M
	Examin		4a. Facility Name (If not institution, g				4b. City,		Location of	of Death			ounty of Dea	ath
	***		5. Social Security Number 6.	Sex 7. AC	je (In yrs. las	t birthdav)	If Under		MURUS If Under	24 Hrs.	8. Date of B			rthplace (State or Foreign
	Funeral Director		215-40-7762	1 <b>⅓</b> M 2□F	61	Yrs.	Months	Days	Hours	Min.	(Month, E	Day, Year)	943	MD
	pur &		Usual Residence of Decedent  10a. State 10b. County		10c. City, 1	Town or Lo	cation							10d. Inside City Limits
	Aanyla f sho	ō	MD N/A			ltimo								1 Yes 2 No
	r 28a-	Director	10e. Street and Number		1		10f. Zip	Code				10g. Citize	on of What C	Country?
	th with		1834 N. Collin	ngton Ave.				212	13			τ	JSA	
	hours after death with the Maryland turat', or Itams 23a or 28a-f show at Exp offerfround be notified at	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Deced	dent of Hi	ispanic Ori n, Mexicar	gin? (Spen, Puerto	ecify Yes or N Rican, etc.)	lo- 14	Race · Am Black, Wh	erican Indian, ite, etc.
36	irs afte	by F	1 ☐ Never Married 2 ☐ Married  3√3/Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No		1 🗆 Yes	2 🔀 No	Specify:			s	Specify: B	lack
Maryland 21215-0036	2 hou	ted	15. Decedent's	Education		16a. Dece	dent's Usua	Occup:	ation	t of work	ina	16b. Kind	of Busines:	
2	ithin 7 ne.	Completed	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or	5+)		kind of wo DO NOT us Self			t or work	ing	Ar	ab	
22	filed within 72 Hygiene. other than "na ant, the Madic		7th  17. Father's Name (First, Middle, La	N/A			serr .	embr		er's Name	e (First, Middl	le Maiden S	umame)	
au	d tal	To Be	George R.	Fitzgerald	1				_	oris		Jones		
ary		-	19a. Informant's Name/Relationship								al Route Num			
	1 and 2 Health a tam 27 is		Doris Fitzgerale	d-mother					ay Ap		10 Bal	-		21205
altimore,	Pages 1 nent of H int: If itae		20a. Method of Disposition 1   Burial 2 □ Cremation 3	Removal from State	cem	ietery, crei	sition (Nar. natory or o noria	ther plac			<sup>2005</sup>		ation - City o Dallst	r Town, State own MD
<u>=</u>	C 00 -3		<ul> <li>4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice</li> </ul>		KII	,					CH FUN			
Ba	permit. Departi Import any inj		> & ladus	14) Ou	کیم		1101					ltimor		
50,	hearing be executed by sicial and physicial and Examiner sthe purial-transit	lical Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if a p. leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a SP ]  Due to (or as	Ine.  CRAII  a consequer  CI  a consequer	once of): SHO(	PNE							Interval Between Onset and Death
.O. Box 687	The law requires that the death certificate ate has been signed by the attending physicage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal de	eath 3	Ectopic pr			3.0		23	d. Date of de Month	blivery Day Year
S, D	res that igned b	by P	Part II. Other significant conditions			ng in the u	nderlying c	ause give	en in Part I.			i		to the cause of death?
ord	w require been si	Completed	END STAGE R									Yes 2.	No 3∐P	robably 4 □Unknown
Records,	has b	mpi	HEPATITUS (	VIRAL	INF	-15C T	LUN.	<b>,</b>			24a. Wa auto per	s an opsy formad?	24b. Were a prior to death?	utopsy findings available completion of cause of
Vital			25. Was case referred to medical						26 Plane	of Death	1 ☐ Yes	20 No		s 2□No
	shysicis this cert al direct	To Be	examiner? 1 ☐ Yes 2 🗙 No	Hospital: 1 Inpatio	ent 2 EP	VOutpatier	it 3 DC	Othe	25		me 5 ☐ Res	111111111111111111111111111111111111111	☐Other (Spe	ecify)
Division of	ing Ph r. After th funeral		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry 28	Bb. Time of Injury		8c. Injury Work	ς?		28d. Describe	how injury o	occurred	
Sio	eath	icat	2 Accident investigat 3 Suicide 6 Could not	be One Blace of In	iun. At home	o form of	M		Yes 2⊡.		28f Location	(Street and )	Numberor	lural Route Number,
Σ	I or Attendate death Director:	Certification:	4 Homicide determine	28e. Place of In building, et	lc. (Specify)	e, ram, str	eer, ractory	, onice			City or To	own, State)	vuniber or A	iurar noute ivuriber,
	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by the	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis o and manner st	of examination	edge, death n and/or in	occurred vestigation	at the tim	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time	e cause(s) ar e, date and p	nd manner a lace, and du	s stated. e to the cause(s)
	To the comp	Σ	29b. Signature and title of certifier						number					th, Day, Year)
0	A		His L		LDEN	-		res-	-000	2		20	1201	2005
7	` `		30. Name and address of person while LIAUG	560111	OCIA R	PALIF	NIR	1111	n I	201	TIMOR	ri- h	110 7	1.17.39
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registr	rar's Signatur	0	P 13	o V	·/	2196	121101	4-, /	(1)	. 03
	Registr		MAY 25	32. Registr	we h	4 19	2040	<i>"</i>						
DH	MH 17 Rev 1/2	001	****	.45		~								

DHMH 17 Rev 1/2001

			For State Registrer	State of Ma	ryland / Depa <i>Cel</i>	artment of He			giene	5 17479
	Physici	an	1. Decedent's Name (First, Middle, La	•	_			2. Date of Dea Month	th	3. Time of Death
	/Medie Examir	čal	ZACHARIAH  4a. Facility Name (If not institution, given	FORSYTH e street and number)	E	4b. City, Town, or L	ocation of Death	May	4c. County o	05 2:55 PM
		iei	UNION MEMORIAL				TIMORE		N/A	
	Funeral Director		230-20-8300	7. Age	(In yrs. last birthday)  Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 4 14	1922	Birthplace (State or Foreign Country)     N.C.
	/land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	e Man te-f eh	Director	MD N/A		Baltimo	ore				1 Yes 2 No
	with th	Dire	10e. Street and Number 1908 Boone Stre	oot		10f. Zip Code 2121	0	1	l0g. Citizen of Wh	nat Country?
	death me 23	Funeral	11. Marital Status	12. Was Decedent E		Was Decedent of His	panic Origin? (Spe	cify Yes or No-	USA 14. Race	- American Indian,
21215-0036	72 hours efter death with the Maryland naturel', or Iteme 23e or 28e-f ehow dical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🌠 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	o	f Yes, specify Cuban 1 ☐ Yes 2 🔀 No	, Mexican, Puerto I Specify:	Rican, etc.)	Black, Specify:	, White, etc. Black
15-0	"natural",	letec	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occupati kind of work done du	ion iring most of workir	ng	16b. Kind of Busi	iness/Industry
212	be filed within 72 ho ital Hygiene. id other than "netu event, the Modical	Completed by	Elementary/Secondary (0-12) 6th	College (1-4or 5+N/A	.)	DO NOT use retired) Chlehem St	eel		Laboi	rer
nd	be filed htal Hygie d other event, II	BeC	17. Father's Name (First, Middle, Last				18. Mother's Name			
Maryland	2 should be for and Mental Bris marked of reumatic ever	2	Gilford  19a. Informant's Name/Relationship (	Forsythe	101 11 11		Pearl		Hooks	
	1 and 2 s Health an Iem 27 Is r other treur		Ivorine Forsythe			ng Address (Street an . Flint Ta				tate, <i>Zip Cod</i> e) 2015
Baltimore,	r in or		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo	***	D			ity or Town, State
ţi m	Pa nen ant:		`4 □Donation 5 □Other (Special	y)	Mt. Zion		5/25/	2005	Baltimo	ore Co. MD
Ba	permit. Departr Importe any inju		21. Signature of Funeral Service Licer	wan	en)   22	. Name and Address	MAR		RAL HOME	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to	he death. Do not ente	1101 E. NO er the mode of dying,	such as cardiac or	respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Myoca	ardial	Infar	ction			Onset and Death
	/Medical Examiner		Tossaming in dealiny	Due to or as a	consequence of):					
	p =	ner	Sequentially list conditions, it any, trauming to immediate cause. Enter Underlying	b. Due to (or as a	Guntequarica of).					
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a	consequence of):					
8760,	e be e. /sician e buria	dicalE		d	0011004001100 017.					
9	ntificating physes as the	w I	IF FEMALE:	V						
.O. Box	that the death certific led by the attending p detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	,
ords, P.	The law requires that ite has been signed b page 2 should be deta	leted by Pł	Part II. Other significant conditions of	ontributing to death but	not resulting in the ur	nderlying cause given	in Part I.			ute to the cause of death?
Vital Records,		Comple						24a. Was ar autops perform 1 Yes 2	v brid	ore autopsy findings available or to completion of cause of ath?  Yes 2 No
Vita	Physicien: Th this certificate al director, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:		Other	26. Place of Death			
) of		1-	27. Manner of Death	1 ☐ Inpatient  28a. Date of Injury (Month, Day)	28b. Time of	28c. Injury a	4   Indising From		ince 6 Other w injury occurred	
sior	[ 호호 : 형	catio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b			M 1 □ Ye	s 2 🗆 No			
Division	or Dire	ertification;	4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, stre (Specify)	et, lactory, office	2	81. Location (Str City or Town	reet and Number , State)	or Rural Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exer	ysician: To the best of niner: On the basis of e and manner state	xamination and/or inv	occurred at the time, estigation, in my opin	, date and place, and inion, death occurred	nd due to the ca d at the time, da	use(s) and mann ate and place, and	er as stated. d due to the cause(s)
)	Tot	7	29b. Signature and title of certifier  W:UAAA	copra 40	)	29c. License n	05410	3	od. Date signed (I	Month, Day, Year)
1	3		14/111	completed cause of dea			morial.	Harrit	al Ra	Itima Mo
	Sta	te	31. Date filed (Month, Day, Year)	1	2		1011011	1 100 KILL	WI DU	minore, m
Dhi	Registr MH 17 Rev 1/20		MAY 2 5 20	105	s Signature	العالمة				

ORIGINAL

			For State Registrate			Maryland / Dep	artment of ertificate o			giene Reg. No: ) (	PA pring to	
	Physici /Medic		1. Decedent's Na	RENE		<del>43 5/25/05 JH</del> H•	Fis		2. Date of Dea Month Ma V	ith Day	Year 2005	3 Time of Death
	Examir		4a. Facility Name	(If not institution, g	give street and numb	per)	4b. City, Town	, or Location of Dea			ity of Death	1111100
1						Hospital		ellville				eorges
	Funeral Director		5. Social Security 215-78	-0618	. Sex 1 M <b>X</b> X ■ 7.	Age (In yrs. last birthday 49 Yrs.	Months Day			r, Year)		place (State or Foreign htry) MD
	land ow		Usual Residence 10a. State	10b. County		10c. City, Town or L	.ocation				1	Od. Inside City Limits
	Mary a-f sh	tor	MD			Mitche:	1155110					1 Tes XNo
	or 284	Director	10e. Street and N	lumber		milcine,	10f. Zip Code			10g. Citizen o	f What Cour	ntry?
	s 23a	ral	759 Fa	raway Ct	-			20721		U.	S.A.	
10	fter de	Funeral	11. Marital Status	s arried 2∐ Married	12. Was Decede	es?	Was Decedent of If Yes, specify Co	f Hispanic Origin? ( uban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Ri	ace - Americ ack, White,	
036	hours after death with the Maryland tural', or Items 23a or 28a-f show al Executiver must be neathed ut	by		4 Divorced	1 ☐ Yes X If Yes, Give Year or Date	es:	1 □ Yes 2X N	lo Specify:		Spec	ify: B	lack
5-0	natu	Completed	(Sp	15. Decedent's ecify only highest of	Education grade completed)	(Giv	edent's Usual Occ e kind of work dor	ne during most of wo	orking	16b. Kind of	Business/Ind	dustry
121	within ene.	duc		condary (0-12)	College (1-4	or 5+)	DO NOT use reti	red)		D.	1- T	
<u>1</u>	illed Hygie other	a	12th gi	e (First, Middle, La	NA =		)isable		me (First, Middle,		sabl	ea
ylar	should by and Menta a marked umatic ev	To B	Kelson	J. Fish	ner			Altha (	G. Roche	•		
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event. The Medical Eracin er matt be multilized ut			Name/Relationship				et and Number or R				
	s 1 and 2 of Health a item 27 is other trau		Sharon 20a. Method of D		Ahmad-S	ister 759 20b. Place of Disp	osition (Name of		-	ville 20c. Location		
altimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 🔀 Burial		☐Removal from Sta		matory or other p	· 1	25/05	Arbut	•	
alti	permit. I Departm Importal any inju			Funeral Service Lic		2	2. Name and Add	ress of Facility	23/03	ALDUI	.us,	nu :
<u> </u>	88 = 88	l li	eft	rome +	t. Thum	pen ?	laren F 1300 Wa	/H West bash Ave	e, Balti	more,	Md	21215
	Prrysician /Medical Examiner	ler	Immediate Caus disease or condi resulting in dealf	e (Final tion h)	a Due to (or	as a consequence of):  as a consequence of):	ler the mode of d	ying, such as cardia	c or respiratory arm	est,		Approximate Interval Between Onset and Death
, 68760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Medical Examiner	if any, leading to cause. Enter Un Cause that initiated ever resulting in death	aerying , ricijury its ) Last	c. Due to (or	as a consequence of):						
.O. Box	that the death certific ed by the attending p detached for use as	Physician/M	23b. Was deceded in the past 1 Yes 2 9 Unknow	12 months?		n 2 ☐ Fetal death 3[ t at time of death 5[	⊒Ectopic pregnan ⊒ Other (specify)	icy		1	ate of deliver onth	ry Day Year
Records, P	w requires that been signed b should be deta	by	Part II. Other sign	nificant conditions	contributing to deat	h but not resulting in the u	ınderlying cause ç	given in Part I.	23e. Did tob	_/		e cause of death?
_		Completed							24a. Was ar autops perform 1 Yes 2	y ned2	prior to con death?	psy findings available apletion of cause of
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case reference?		Hospital:				ath (Check only on			(i) sile si
on of	Jing After fune	$\vdash$	27. Manner of De	5 Pending	28a. Date of I		f 28c. Inj	ury at ork?	dome 5 Reside 28d. Describe ho			)
Division of	Attender deatlest dea	Certification	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigati 6	be 28e. Place of	Injury - At home, farm, st etc. (Specify)		_Yes 2 □No e	28f. Location (Str City or Town	reet and Num , State)	ber or Rural	Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in 1	edical (	29a. Certifier (Check only one)	1 Certifying F 2 Medical Exa	Physician: To the beaminer: On the basis	est of my knowledge, deat s of examination and/or in stated.	h occurred at the vestigation, in my	time, date and place opinion, death occu	and due to the ca arred at the time, da	use(s) and mate and place,	anner as sta	ited. the cause(s)
•	To the within to the comp	Me	29b. Signature an	d-title of certifier	MY.	7	29c. Licer	nse number	29	9d. Date signe	ed (Month, D	Pay, Year)
1	3		30. Name and ad	dress of person who	completed cause of	of death (Item 23a) (Type,	Print) 620	1 GREA	WACKA	ROPE	I d	#3
	Sta Registra		31. Date filed (Mo	MAY 2 5 2		strar's Signature	uli)	CORA DX	WARK	NY	2 30	740

amend item/5, per FH, 6844, 6/6/05 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** May 20 Edward Fulton 2005 10:30p<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Nursing Home TOWSON

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Baltimore 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 217-58-5042 1**X** M 2 □ F Months Director <del>215-58-5042</del> 53 09 MD Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location show 10d. Inside City Limits an "natural", or Itams 23s or 28s-f show Medical Examiner must be notified at Director 1 X Yes 2 □ No MDNA Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? with Funeral 3501 Dennlyn Road 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Elementary/Secondary (0-12) College (1-4or 5+) 9 12th grade 6 yrs State Delegate State of Maryland other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maryland is 1 and 2 should be fill. Health and Mental Hitam 27 is marked ot 2 Helen Darling George Fulton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Itam 27 is any injury or other tra Dr. Jacqueline Fulton-Wife 3501 Dennlyn Road, Baltimore, Md 21215 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 5/27/05 Randallstown, Nd 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part I. Enter the disease, or complications that caused in deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart believe. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AncreAtic CANCER **Physician** ear /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medlcal as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ö in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown þ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ρ 1 ☐ Yes 200 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 No 1 Yes of Vital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check on ne Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospic Ho spital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Division 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a 1 Propertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and atle of pertifier 29c. License number 29d. Date signed (Month, Day, Year) MAY 21, 2005 my 25205 pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who 6601 N. Charles Street Towson, MD 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar	State of	Maryland		artment of H		and Me		iene	nne	17100
			Decedent's Name (First, Middle,	Last)						2. Date of Dea	th		3. Time of Beath
	Physici /Medic		Thomas Melvin	Fisher	III					Month Mav	Day 22	2005	10:10 p <sup>M</sup>
	Examin	_	4a. Facility Name (If not institution,	give street and numb	oer)		4b. City, Town, or	Location o				nty of Death	10.10
		м	Millennium Heal	th Care C	enter		Glen Bur	rnie			Ann	e Arur	ndel
	Funeral		5. Social Security Number 6		. Age (In yrs. Ia.	st birthday)	If Under 1 Year Months Days	If Under a		8. Date of Birth	Year)	9. Birthr	place (State or Foreign
	Director		215-22-9031	1 <b>X</b> M 2□ F	77	Yrs.	World Day o	110010		10/15/1	927		yĺand
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	cation					1.	IOd. Inside City Limits
	sho	'n											1 ☐ Yes 2 ☑ No
	the N	ect	Maryland Anne A	rundel	GIE	n Bur	10f. Zip Code			1	On Citizan	of What Cour	
	with	by Funeral Directo	7575 East Howard	Road			21060	1		'	•	SA	iuy r
	eath	era	11. Marital Status	12. Was Deced	ent Ever in U.S.	. 13. V			nin? (Spec	cify Yes or No-		ace - Americ	can Indian
	fter d	핊	1 □ Never Married 2 ★ Married	Armed Force	es? 194	J-	Was Decedent of Hi f Yes, specify Cuba	n, Mexican	, Puerto F	lican, etc.)		lack, White,	
9	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dat	es: 194	8	1 ☐ Yes 2 █ <b>X</b> No	Specify:			Spe	cify: Wh	ite
Õ	filed within 72 hours after death with the Maryland Hygiene. other then "naturel", or Items 23a or 28a-f show ent, the Medical Exemple investible modified	Completed	15. Decedent's (Specify only highest			16a. Deced	ient's Usual Occupa	ation	of workin		16b. Kind of	Business/In	dustry
2	thin the	npie	Elementary/Secondary (0-12)	College (1-4	lor 5+)		kind of work done of DO NOT use retired		O WOIKII	9			
7	ygien ygien t, the	Con	8			St	upervisor					ilroad	
Maryland 21215-0036	fal H d oth	Be	17. Father's Name (First, Middle, La							(First, Middle, i	Maiden Sum	am <i>e)</i>	
$\frac{1}{2}$	ould Men Marke Marke	ို	Thomas Melvin F						lyn	Sutch			
<u>ā</u>	12 sh h and 7 Is n reun		19a. Informant's Name/Relationship				g Address (Street a						- 1
e,	1 and Health		Madeleine Parki  20a. Method of Disposition	nson (Dau			Native D sition (Name of	ancer				1D 214 n - City or To	
altimore,	iges if it		1 Burial 2 Tcremation 3		ate cer	metery, cren	natory or other place	.					
≣	rfmer rfmer rfent njury		'4 □Donation 5 □Other (Spe		Met		ematory			4,2005	Baltin	nore,	MD
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Exercities must be rediffed any injury or other treumatic event, the Medical Exercities must be rediffed any ones.		21. Signature of Funeral Service 1	Ansee			Name and Addres	Funer	al H				
		_	23a. Part1. Enter the disease, or co	omplications that cau	used the death.		12 Ridgel					21401	Approximate
			shock, or heart failure. List or Immediate Cause (Final	nly one cause on	h line.			-					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Dua to (or	as a conseque	anco of	711411	orvice		1	-		
В	Examiner			~ (	hronic	CU	faile	Le	ua	l fa	e/ we	2.	
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseque	ence of):				-			
	cuted nd ransii	Examiner	that initiated events	с									
Ő,	rate be executed hysician and the burial-fransit	EX	resulting in death) Last	Due to (or	r as a conseque	ence of):							
8760,	icate be executed physician and s the burial-fransit	dicai	l	d					-			-	
9	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as t	/Me	IF FEMALE:	23c. If yes, outco	me of presentati	CV						contemporario	NAME:
Box	atfen for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1☐Live birt	h 2 ☐ Fetal d nt at time of dea	death 3	Ectopic pregnancy Other (specify)					Date of delive Month	Day Year
o.	that the de ned by the a detached t	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknow		0	Caron (opecary)						
۵.	res that igned b be deta	by Pr	Part II. Other significant condition	s contributing to dea	th buy not result	ting in the ur	nderlying cause give	en in Part I.		23e. Did tol	pacco use co	ontribute to th	ne cause of death?
Records,	quires n sigr	d b	Tailu	e D	HAVI	ue				1 □ Y	s 2 No	3 🗌 Prob	ably 4 Onknown
00	tw require s been si	Completed								24a. Was a	n 241	o. Were auto	psy findings available
Re	The lav fe has age 2	Elo								autops	ned?	prior to condeath?	psy findings available mpletion of cause of
Vita	en: tifica tor, p	0	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes : (Check only on		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2[]140
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0	ng Ph fer th heral	no.	27. Manner of Seath	28a. Date of	Injury 2 Day Year) 2	28b. Time of Injury	28c. Injury Work	at	2	8d. Describe ho	w injury occ	urred	
0	ttendir death. stor: Al	atic						Yes 2 1	Vo				
Division of	frer de lirect	Certification:	3 Suicide 6 Could no 4 Homicide determine	ad 288. Place 0	f Injury - At hom g, etc. (Specify)	ne, farm, stre	eet, factory, office		2	Bf. Location (St City or Town		mber or Rura	l Route Number,
	urs af urs af erel D		A										
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2) Medical Ex	Physician: To the bas aminer: On the bas and manne	is of examination	ledge, death on and/or inv	occurred at the tim restigation, in my op	ne, date and pinion, deat	d place, a th occurre	nd due to the ca d at the time, d	ause(s) and a ate and plac	manner as si e, and due to	tated. the cause(s)
	To the withing To the company	ž	29b. Signature and title of certifier				29c. License	number	×			ned (Month,	
	O		IA				D57	098	<b>S</b>			3-0	
4	4		ADITY'A CHOPRI	no completed cause	of death (Item 2	23a) (Туре. D6ED	Print) AVE#	231 1	ANNA	APOLLS	, MC	214	01
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2	5 2005 <sup>32. Rg</sup>	strar's Signatu	B. A	berte				,		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Physician /Medical Examiner    Marcollan	Death  4c. County of Deeth  N/A  e of Birth  nth, Day, Year)  -03-1908  10g. Citizen of What Cour  U. S. A.  s or No- Black, White,  Specify:  16b. Kind of Business/Inc.  OWN  HC	ean Indian, etc. VHITE
Medical Examiner   4a. Facility Name (If not institution, give street and number)   4b. City, Town, or Location of ROLAND PARK PLACE   BALTIMORE	4c. County of Deeth  N/A  e of Birth nth, Day, Year) -03-1908  10g. Citizen of What Cour U. S. A. s or No- electric Black, White, Specify:  16b. Kind of Business/Inc.	blace (State or Foreign ntry) TH CAROLINA 10d. Inside City Limits XXX Yes 2□No ntry?  can Indian, etc.
ROLAND PARK PLACE  Funeral Director  Social Security Number 6. Sex 1 Months Days Hours Min. (Mor Observed Control of Decedent)  1 M XXI F 97 Yrs.  BALTIMORE 8. Date (Mor Months Days Hours Min. 05-	N/A e of Birth nth, Day, Year) -03-1908  10g. Citizen of What Cour U. S. A. s or No- slic.)  14. Race - Americ Black, White, Specify: V  16b. Kind of Business/Inc  OWN HC	TH CAROLINA  10d. Inside City Limits  XXX Yes 2 □ No  ntry?  can Indian, etc.
Funeral Director  5. Social Security Number 219-58-3450  Usual Residence of Decedent  6. Sex 7. Age (In yrs. last birthday) 97 Yrs.  7. Age (In yrs. last birthday) Months Days Hours Min. 05-	9. Birthn Cournell Page 1998   9. Birthn Cournell Page 1998   9. Birthn Cournell Page 1998   9. Birthn Cournell Page 1998   9. Birthn Cournell Page 1998   10g. Citizen of What Cournell Page 1998   1. Cournell Page 1998   1	TH CAROLINA  10d. Inside City Limits  XXX Yes 2 □ No  ntry?  can Indian, etc.
	10g. Citizen of What Cour U. S. A. s or No- ltc.)  14. Race - Americ Black, White, Specify:  16b. Kind of Business/Inc.  OWN HC	XXX Yes 2 □ No ntry?  - can Indian, etc.  WHITE
MD. N/A  BALTIMORE  10e. Street and Number  830 WEST 40th. STREET  11. Marital Status  1	10g. Citizen of What Cour U. S. A. s or No- ltc.)  14. Race - Americ Black, White, Specify:  16b. Kind of Business/Inc.  OWN HC	XXX Yes 2 □ No ntry?  - can Indian, etc.  WHITE
10. Street and Number  830 WEST 40th. STREET  21211  11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 3 Never Never or Dates:  1 Never Married 2 Married  1 Never Married 3 Never Never or Dates:  1 Never Married 3 Nevre Never or Dates:  1 Never Married 3 Never Never or Dates:  1 Never Married 3 Never Never or Dates:  1 Never Married 3 Never Never or Dates:  1 Never Married 3 Never Never or Dates:  1 Never Married 3 Never Never or Dates:  1 Never Married 3 Never Never or Dates:  1 Never Married 3 Never Never or Dates:  1 Never Married 3 Never Never or Dates:  1 Never Married 4 Divorced  1 Never Married 5 Never Never or Dates:  1 Never Married 2 Never Never Never Never or Dates:  1 Never Married 2 Never Ne	U. S. A. s or No- latc.)  14. Race - Americ Black, White, Specify:  16b. Kind of Business/Inc  OWN HC	ean Indian, etc. VHITE
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15. Decedent's Education (Specify only highest grade completed)  [Specify only highest	оwи но	dustry
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SAMUEL H. MARSHALL MARGARET	r L. STOCKS	
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20a. Method of Disposition  1 Burial 2XXCremation 3 Removal from State  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  RIICK TOWSON FUNERAL HOM	20c. Location - City or To TOWSON, MARYL	
21. Signature of Funeral Service Licensee  RUCK TOWSON FUNERAL HOM	1050 YOR ME,INC. TOWSON,M	
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirations, or heart failure. List only one cause on each line.	atory arrest,	Approximate Interval Between
Physician /Medical Examiner  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	disease	Years
Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):  A. Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (		
Box 68 Box 68 leath certifica attending plant		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	o. Did tobacço use contribute to	the cause of death?
of the second of	1 √es 2 No 3 Prob	eably 4 Unknown
Page 24a.  2	performed? ava	ere autopsy findings ailable prior to apletion of cause death?
	1 □ Yes 2 1 No 1 □	]Yes 2□No
25. Was case referred to medical examiner?	only one)	
+ × ∞ 5   2   1 □ Tes 2 □ PNO   1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA   1 □ 1 □ Home 5 □	Residence 6 Other (Specify, cribe how injury occurred	)
3 Suicide 4 Homicide    Suicide   Su	ation (Street and Number or Rural or Town, State)	Route Number,
The standard of the standard o	to the cause(s) and manner as ste time, date and place, and due to	eted. the cause(s)
29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  25c. License number	29d. Date signed (Month, D. 704 23, 200	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MARY J. JRFUE MACRIEGOR RODGE PARK PLAF	BA(TO. M	\
State Registrar  31. Date filed (Month, Day, Year) 2 5 200 5 200 5 200 5 200 5 200 5 200 5 200 5 200 5 200 5 200 5 200 5 200 5 200 5 200 5 200 5 200 5 200 5 200 5 200 5 200 5	CHU., M	<b>~</b>

## Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate	of Death		Reg. No.		
Physician	1. Decedent's Neme (First, Middle, Las	MABEL E.	EOM ED		2. Dete of Dee Month	Dey Y	3. Time o	
/Medical			FOWLER		MAY	21, 20	05 4:20	) PM
Examiner	4a Fecility Neme (If not institution, give OAK CREST	CARE CENTER		4b. City, Town, or L	ILLE	BA	LTIMORE	
Funeral Director	217 30 0013	7. Age (In yrs. 87	lest birthday) if Under 1 Months E	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birt (Month, De) 01-22-	h, Year) -1918	Birthplece (State Country) MARYLAN	or Foreigr ID
show start	Usuel Residence of Decedent 10a. Stete 10b. County	10c. Cit	y, Town or Location				10d. inside C	City Limits
with the Marylar or 28s-1 show	MD. BALT	MORE	10f. Zip Co	PARKVILLE		10g. Citizen of Who		s 2 <b>X</b> XNo
23a or unit be r		BOULEVARD		21234		U. :	S. A.	
72 hours after death with the Meryland natural; or items 23s or 28s-f show dicel Exeminar must be notified at eted by Funeral Director	11. Merital Status  1 □ Never Married 2 □ Married  XX Widowed 4 □ Divorced	12. Was Decedent Ever in U, Armed Forces? 1V Wes 2 ☐ No If Yes, Give Year or Dates: W . W	A	t of Hispenic Origin? (Sp Cuben, Mexican, Puerto Xno <i>Specify:</i>	pecify Yes or No- Pican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. WHITE	
n 72 hor natura	15. Decedent's Edi (Specify only highest gred	ucation le completed)	16e. Decedent's Usual C (Give kind of work of life. DO NDT use	Occupation fone during most of work	king	16b. Kind of Busin	72	
e filed within 72 ho al Hygiana. other than "nature vent, the Medical. Se Completed	Elementary/Secondary (0-12)	4 YEARS	REGIST	ERED NURS	Ε	HEALTH	CARE	
Mantal H Mantal H arked oth	17. Father's Neme (First, Middle, Last)  JOHN		CORKRAN	ЕТН	EL JUL			
d 2 la a la a la a la a la a la a la a l	19a. Informant's Neme/Relationship (T THOMAS B. FOWLER,		19b. Mailing Address (S	STREET N.W.				
Pagas 1 and and of Haalint: If Item 2'y or other	20a. Method of Disposition  1XXX Surial 2 □ Cremation 3 □ I  4 □ Donation 5 □ Other (Specify,	Removal from State	lace of Disposition (Name emetery, crematory or othe RELAND MEM.P.	r place)	Date -26-2005	20c. Location - Cit PARKVII	ty or Town, State	
parmit. Pagas Department of Important: If it any Injury or on the control of the	21. Signature of Funeral Service Licens			Address of Facility	_ HOME.I			)AD 204
_	23e. Pert1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the deetl					Approxima Interval Be	ite
Physician /Medical Examiner	Immediate Ceuse (Final diseese or condition resulting in death)	a. <u>320515</u> Due to (o	Bacter:	a l			Onset and	Death
cartificate be assocuted rding physician and use as the bunal-transit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest	history	es e consequence of):  of col as e consequence of):		nces	_		
death of for u	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the undertying cause	se given in Part I.	23b. Did t	obacco use contri	bute to the cause	of death
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aw require	atrial	Fibrilla	-tien		24a. Wes a	an autopsy 2 med?	24b. Were autopsy available prior completion of of death?	to
Tha le					101	38 21110	1 ☐ Yes 2 ☐	JN0
cartificata ractor, pag	25. Was case referred to medical examiner?	Hospital:		26. Place of Dea Other:				
arthis ca aral dira	27. Menner of Deeth	1 ☐ Inpatient 2 ☐  28e. Date of Injury (Month, Dey Year)	ER/Outpatient 3□ DOA 28b. Time of 28c.	4 → Nursing Ho Injury at Work?		lence 6 DOther (	(Specify)	
tal or Attending P is after death. al Director: After ti lad in by the funera Certification:	1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		Injury M ome, ferm, street, factory, o	1 ☐ Yes 2 ☐ No	28f. Location /S	Street and Number	or Rural Route Nur	mber.
tal or A as aftar all Directly Certify	4 Homicide determined	building, etc. (Specif	/)		City or Tow	m, State)		
To the Hospital or Attending Physician: within 24 hours aftar death.  To the Funeral Director: Attar this cartific complataly filled in by the funeral director, Medical Certification: To Be (	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowner: On the basis of examination end menner stated.	wledge, deeth occurred at to ion end/or investigation, in	he time, date and place, my opinion, death occur	end due to the or red at the time, or	cause(s) end mann date and place, and	er as steted.  I due to the cause(	(s)
To th To th comp	29b. Signature end title of certifier	An		icense number		May 2	Month, Dey, Year)	-
il N	30. Neme end eddress of person who c	ompleted cause of death (Item	-	30076		1.10.9	- 5 200	)
State	31. Dete filed (Month, Day, Year) MAY 2 5 2005	32. Registrer's Signe		Parku	No , d	10 2	12-34	
Registrar	MAY ≈ 5 2005	Benesa H	Sparks					
UNIU 46 Day 665		-	100					

**ORIGINAL** 

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** EDITH GOVER 05 21 2:45 PM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD MARINER HEALTH OF FOREST HILL FOREST HILL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 DF Months Days Hours Min. 94 218-07-1543 Director Nov. 22, 1910 Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a, State or 28a-f show other treumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 € No Director Harford Jarrettsville Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21084 U.S.A. 2044 Nelson Mill Road or items 23a death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other treumetic event, the Midical Examinations. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify. white 3 □tWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) government factory worker 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Catherine Merson James Creswell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2044 Nelson Mill Road, Jarrettsville, Md. 21084 Yvonne Isennock/granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk. 5/25/05 Elkridge, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licenses 610 W. MacPhail Road, Bel Air, Md. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Parker **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records. P.O. detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2N No 20 No 1 Yes 2 No the Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 Yes 1 Inpatient ٩ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 5 Pending 1 ☐Yes 2 ☐ No within 24 hours after death. To tha Funaral Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifies 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mar 0 22299 23 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. MACPHAIL ROAD DR. DAVID DUNN BEL AIR, MD 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 16 **Physician** 2ŎŨ5 10:44 P M Tierra Green /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** North Arundel Hospital Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) May 24 19 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X F 5 Yrs 1999 215-55-5001 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c City Town or Location 10a. State 10b. County item 27 is marked other then "neturel", or Items 23s or 28e-1 show other treumstic event, the Macical Examiner must be notified at 1 ☐ Yes 2 No N/A Baltimore Maryland Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2680 Dulany St. 21223 Pages 1 and 2 should be filed within 72 hours after death vent of Heatth and Mental Hygiene. Ant: If item 27 is marked other then "neturel", or Items 23s Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Pre-K N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Linette Wallace Michael Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 802 Ridgewick Rd. Glen Burnie, Md. 21061 Michael Green(Father) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ō 5/24/05 Hanover, Md. St. Rest Cemetery permit. Page Department of Importent: If any Injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) <sup>22 Name and Address of Facility</sup> Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 21. Signature of Funeral Service Licenses B. Keese MOO483 Larry 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multiple in wies **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner requires that the death certificate be executed attending physician end for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 X No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 1 Yes 2 □ No 24a. Was an autopsy performed 1 Yes 2 No certificate Hospitel or Attending Physicien: After this certific funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner' Hospital: 1 | Inpatient 2 ER/Outpatient 3 DOA Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death injury a Work? passenger of a motor vehicle that 1 Natural 1 ☐ Yes 2 No 5-16-05 9:58 collided with another motor vehill investigation 24 hours after death 2 Accident 28f. Location (Street and Number of Rural Route Number, City or Town, State) \$3 Kt. 648 (2) Rt. 97 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, elc. (Specify) þ 4 - Homicide Road Ferndale mD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 17, 2005 m.D *Ki* OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore Maryland 21201 MID LING 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

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DHMH 17 Rev 1/2001

Registrar

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		For State Registrar	State of M	laryland / D	epartment Certificate				giene () ( Reg. No.	)5	17490	
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/Medic	ral Harry Critical Gribert									2005	5:55 AM	
Examin	er	4a. Facility Name (If not institution, give		A se			ation of Death		4c. Count	of Death		
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yland		10a. State 10b. County		10c. City, Town	or Location					11	Od. Inside City Limits	
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r dea	Funeral	Tr. Markar States	<ol><li>Was Deceden Armed Forces</li></ol>	?	13. Was Deced If Yes, spec	ent of Hispa ify Cuban, M	nic Origin? (S lexican, Puert	pecify Yes or No- o Rican, etc.)	- 14. Ra	ce - Americ ck, White, e		
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permit. Pagas 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other trsumatic event, the Medical Exact or must be notified at once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ☒ Donation 5 ☐ Other (Specify)	lemoval from State	cemetery	Disposition (Nam , crematory or of			Date	20c. Location	- City or To	wn, State	
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To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Action								oer or Rura	l Route Number,	
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	edical (											
To th within To th comp	Me	29b. Signature and title of certifier 29c. License number 29						29d. Date signe	d (Month, L	Day, Year)		
		Shalim B							Marx	17,	2005	
		30. Name and address of person who co	ompleted cause of	death (Item 23a) (T	ype, Print)							
		SHALINI BO	DYAPAT		SIN	ALL	HOSPI	TAL O	F BAL	TIMI	ORE	
Sta Registr		31. Date filed (Month, Day, Year) MAY 2 5 2005	2. Regis	trar's Signature	cartes							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1- State Amend Items 24a, 25, 26, 27 per Derin 243, 05/124/105dhb 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** May 15. 2005 Charles Edward Gendron 8:53 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Casey House Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) Mar 28, 1947 Birthplace (State or Foreign Country)
 Maine 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1X M 2□ F 58 Yrs. 016-36-0752 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show in then "naturel", or Items 23a or 28a-f show the Medical Examiner must be notified at Montgomery Village Montgomery 1 ☐ Yes 2X No Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9906 Maple Leaf Drive 20886 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: white Specify þ 3 ☐ Widowed 4 ☐ Divorced 64-68 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) salesperson new homes 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) nd Mental I Pages 1 and 2 should be Charles Edward Gendron Sr Edith Marie Lizotte 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9906 Maple Leaf Drive Montgomery Village, MD 20886 Mary Lou Gendron/spouse If Item 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any Injury or once. \* 4 X Donation 5 Other (Specify) 21. Signature of Euneral Service Licensee Ronald S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 uncer 23a. Part 1 Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final disease or condition resulting in death) **Physician** metastatic colon cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner sician and e burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical the phy use as attending for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? certificate 1 Yes 2X No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence X Other (Specify) Hospice 2 **N**0 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 5 Pending 1 Alatural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide after within 24 hours a To the Funaral C Hospital 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

MAY 2 5 2005

31. Date filed (Month, Day, Year)



38) Name and address of person who completed cause of death (Item 23a) (Type, Print)

3altimore, Maryland 21215-0036

Box 68760

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Records.

Division of Vital

State of Maryland / Department of Health and Mental Hygiene? [] [] 5 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** LORETTA HALL 17 1736 MMY 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MIM BALTIMORE UNIVERSITY OF MARYLANDMEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-5-1938 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Min. Days Hours 1 □ M 2 □ F 66 Welford, SC 160-32-4129 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County traumetic event, the Mudical Examiner notes be notified at 1 TYes 2 □ No MD. Baltimore Windsor Mill Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 40 Heraldy Court Items 23a 21244 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Menta! Hygiene. nent of Health and Menta! Hygiene. ant: If item 27 Is marked other than "netural", or Itel 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ano Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Public School Teacher 5+ 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Essie Gertrude Curry Boyd C. Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Boydena W. Lummis Phila PA 19119 20c. Location - City or Town, State 438 E. Durham St. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Phila Department of H Important: If ite any injury or ot soce. 1 □ Burial 2 □ Cremation 3 □ Removal from State 5-23-05 1201 Easton Rd. PA. ^ 4 □ Donation 5 □ Other (Specify) Ivy Hill Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MARCH FUNERAL HOME-EAST ladi Women 21202 1101 E. North Avenue Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC BREAST CANCER **Physician** disease or condition resulting in death) /Medical Examiner METASTASIS to MEDIASTINUM, LIVER, BONE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) 68760 Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) P.O. the þ n signed b uld be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an cate has l autopsy 2 No certificate 1 Yes Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 Tes 2 No death. investigation after death 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funerel C 29a. Certifier t 🕇 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of oprtifier Jam MD MAY 17, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South GREENE ST Jorge Lozano BACTIMORE, MD 31. Date filed (Month, Day, Year) MAY 2 5 2005 Begistrar's Signature Market Street Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

ician	_	Decedent's Name (First, Middle, I						2.	Date of Death Month	Day	Year	3. Time of			
dical	_	NAT	HANIEL	HARRELL					May 23,			7:22	P		
niner	4 -	a. Fecility Name (If not institution, g		mber)		4b. City, Town, or Location of Death				4c. County of Death					
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al or	5. Social Security Number 212-58-6300 6. Sex 7. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 18. Days Hours Min. 0691-471 951.									951	9. Birthp Cour MARY	piace (State or htry) LAND	Fore		
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Director	10	De. Street and Number				10f. Zip Code				g. Citizen of	itizen of What Country?				
aiD		1534 N. ROSEDA				212	21216 USA			JSA					
Funerai	11	1. Marital Status		edent Ever US		Was Decedent of f Yes, specify Cu	Hispanic Or ban, Mexicar	igin? (Specif n, Puerto Ric	y Yes or No- an, etc.)		ce - Americack, White,				
by Fu		Never Married 2 Married	If Yes, Gr	<sup>2</sup> □No ARM	5 <i>7</i>	1 □ Yes 2 N	37			ack, White, etc. BLACK					
d be	-	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or D	ates:	16a Dece	fent's Usual Occ				6h Kind of F	<u> </u>				
Completed		(Specify only highest	grade completed)		(Give	kind of work don DO NOT use reti	rk done during most of working se retired)			OD. KING OF E	nd of Business/Industry				
m o		Elementary/Secondary (0-12) 12TH	2 YEAR	S	SELF	-EMPLOYI				SELF-E	ELF-EMPLOYED				
BeC		7. Father's Name (First, Middle, La	ist)				18. Mothe	er's Name (F	irst, Middle, M	a <i>iden Sum</i> a	me)				
To E		CLARENCE HA	RRELL				L	ILLIE	MAE MCI	FADDEN	Ţ				
once.  To Be Completed by Funeral Director	1	9a. Informant's Name/Relationship PATRICIA GLADNE		ER		ng Address (Streen NORFOLE				-					
	20	Da. Method of Disposition	_			sition (Name of	PERDV	Date	2	0c. Location	- City or To	own, State			
	1	Burial 2 Cremation 3			WNSVIL			5/27/0		ROWNSV		MD			
혅	2	1. Signatural Service Lic	censee	1	) 22	. Name and Add	ress of Facili	ity HOWE	LL FUNI	ERAL H	OME	21207			
ä		11 Illiano	10.	Nou	4 48	OO LIBE	RTY HE	IGHTS	AVE., I	BALTIM	IORE,	MD			
1	2	23a. Parts. Enter the disease, or co shock, or heart failure. List or	omplications that only one cause on e	aused the death	Do not ent	er the mode of d	ing, such as	cardiac or re	spiratory arres	st,		Approximate Interval Betw	reen		
ın	Ir	mmediate Cause (Final lisease or condition				arcinoma						Onset and D	eath		
al.	re	esulting in death)	a	(or as a consequ				-							
er	9	Sequentially list conditions	b												
iner	if	Sequentially list conditions, any, leading to immediate ause. Enter Underlying cause (Disease or injury	Due to	(or as a consequ	uence of):										
Examiner	th	Cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):													
cai E			Due to	(or as a consequ	derice or).										
			d												
Physician/Med	IF	F FEMALE:	23c. If yes, ou	tcome of pregna	ncy					23d D	ate of delive	arv			
cian	2	3b. Was decedent pregnant in the past 12 months?	1 Live b	einth 2 ☐ Fetal nant at time of de	death 3[	Ectopic pregnar Other (specify)	су				onth		ear		
ysi		1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkn												
by Pl		art II. Other significant conditions	s contributing to d	eath but not resi	ulting in the u	nderlying cause	given in Part I	I.	23e. Did toba	acco use cor	ntribute to th	he cause of de	ath?		
									1 🗌 Yes	2 □ No	3 Prob	ably 4 🗍 U	ikno		
Completed									24a. Was an			psy findings a			
E									autopsy perform	ed?	death?	mpletion of ca	150		
- 0	2	5. Was case referred to medical					26. Place	e of Death (C	heck only one		192 103	20110	-		
e Co		examiner? TX Yes 2 No	Hospital:	Inpatient 20	ER/Outpatier	it 3 DOA	thor		5 🗌 Residen		her (Specif	ý)			
o Be		7. Manner of Death	28a. Date	of Injury	28b. Time o	28c. In	ury at					-			
To Be	. –	1 X Natural 5 Pending (Month, Day Year) Injury Work?													
on: To Be	. –	2 Accident investigation	tion	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 789 Blace of lating. At home form street feature of the could not be 789 Blace of lating. At home form street feature of the could not be 789 Blace of lating. At home form street feature of the could not be 789 Blace of lating.											
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on: To Be	. –	2 Accident investigat 3 Suicide 6 Could no	tion t be 28e. Place	of Injury - At ho	ome, farm, sti	eet, factory, offic	9		City or Town,	State)			0r,		
on: To Be	27	2 Accident 3 Suicide 4 Homicide investigat 6 Could no determin	tion t be ed 28e. Place build  Physician: To the caminer: On the b	ing, etc. (Specify best of my kno	v) wledge, deat	n occurred at the	time, date ar		due to the cau	use(s) and m		tated.	<i>01</i> ,		
on: To Be	27	2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only (Check	tion t be ed 28e. Place build  Physician: To the caminer: On the b	best of my kno	v) wledge, deat	n occurred at the vestigation, in my	time, date ar r opinion, dea		due to the cau at the time, dat	use(s) and me and place	, and due to ed (Month,	tated. the cause(s)  Day, Year)	er,		
edical Certification: To Be	27	2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  1 Certifying 2 Medical Expansion	tion t be ed 28e. Place build  Physician: To the caminer: On the b	best of my kno	v) wledge, deat	n occurred at the vestigation, in my	time, date ar		due to the cau at the time, dat	use(s) and m	, and due to ed (Month,	tated. the cause(s)  Day, Year)			
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Darrell Kevir	ı I	Tolland, 2nd									
05-03484		Pleas	se Type or Pr	int in Blac	k Indelit	ole Ink	. Ensure A	II Copies /	Are Leg	ible.	
Unk. RJD		For State Registrar	State of M	•	Departme <i>Certific</i>		Health and N Death		iene		17101
		Decedent's Name (First, Middle)		ſ		•		2. Date of Death	1	Year	3. Time of Death
Physicia /Medic		Darrell !	+	tol land		•		May 20,			0015А. м
Examine	er	4a. Facility Name (If not institution		er)		ity, Town, c 1timo	or Location of Death OPE			y of Death	
Funeral		Johns Hopkins 5. Social Security Number	6. Sex 7. /	Age (In yrs. last bir		der 1 Year	If Under 24 Hrs.	8. Date of Birth Month, Day,			lace (State or Foreign
Director		213-06-3500	M 2□ F	21	Yrs.	Days	Tiours Will.	2-1-	84	Ma	ryland
laryland show		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Location					1	0d. Inside City Limits
with the Marylar	ctor	141)		Bal	Him	rore	ノ	····			Yes 2 No
with th	Funeral Director	10e. Street and Number	dha. za	e, AU	· ·	Zip Code	230	10	og. Citizen of	What Cour	itry?
ier death w items 23e	neral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S.		ecedent of h	Hispanic Origin? (Spean, Mexican, Puerto	pecify Yes or No-		ce - Americ	
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "neture!", or Items 23e or 28e-1 show eumstic event, the Medical Evantire rough be rediffed at	y Fur	Never Married 2 Marr	ed 1 ☐ Yes 2 If Yes, Give	No		s 2 No		riidan, etc.)	Speci	D	lack.
5-003	ed by	3 Widowed 4 Divorced	's Education	s:	. Decedent's t	Jsual Occup	pation		16b. Kind of E	Business/Inc	fustry
215 thin 72 Medic	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed)  College_(1-4c)	or 5+)	(Give kind of	T use retire		king	Ind	ust	rial
121 lied will tygien nt, ther th		17. Father's Name (First, Middle,	Layen	rs	tre	xes		ne (First, Middle, N	Maiden Suma	bor	er.
fore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours aft it of Health and Mental Hygiene. If item 27 is marked other then "neturel", or or other treumatic event, the Medical Evant	o Be	Da ore 11 K.	Holland	SR.			Yold	and a	·M	05	1011
ary should and M smark	⊢,	19a. Informant's Name/Relations	nip (Type, Print) (Fa	Her) 196	. Mailing Add	ress (Street	and Number or Ru	ral Route Number,	City or Towr	, State, Zip	Code
≥ 5 ± 2 ±		DarrellK	· Holland	1 57-2	049 I Disposition (	MOC	odbou	PALE S	ACCE 20c. Location	Bak	10MD 21239
Pages 1		20a. Method of Disposition  1 Seurial 2 Cremation		comete	ry, crematory		16 5/	7/05	Ro 14	6. M	L/\)
Baltimore, permit. Pages 1 ar Department of Hear importent: If item eny injury or other once.		' 4 □Donation 5 □Other (S		Du	12/2	and Addre	ess of Ficility		Free	200	Enies
Dapa permi Dapa impo eny is		I lun le	, Sunt	>	19	963	Jak	Rd. J	3alte	MO	21212
		23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on each	n line.			ing, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Finat disease or condition resulting in death)	u	Skot Wo		2)0	f Tovso	and Ar	W		
Examiner			b	as a consequence	0.1).						
고 당	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or		-						
xecuted and Il-transit	Exam	Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence	of):						
760 e be e rsician e burig			d								
68. rtificat	Medi	IF FEMALE:								-	
Box ath ce ath ce or use	lan/I	23b. Was decedent pregnant in the past 12 months?		me of pregnancy n 2  Fetal death t at time ol death	3 □Ectop	ic pregnanc	;y			ate ol delive onth	ery Day Year
the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknow		2 Citiei	(specily)_					
Division of Vital Records, P.O. Box 68760, or Attending Physicien: The law requires that the death certificate be executer death.  Director: After this certificate has been signed by the attending physician are in by the funeral director, page 2 should be detached for use as the burial-till in by the funeral director, page 2.	by Physician/Medical	Part II. Other significant condition	ns contributing to deat	h but not resulting i	in the underlyi	ng cause gr	ven in Part I.		V.		ne cause of death?
ords	ted !							1 🗆 Ye	1		ably 4 Unknown
Peco Biawr has be	Completed							24a. Was ar autops	y .	prior to col	psy findings available appletion of cause of
n: Th		25. Was case referred to medica					26 Place of Dea	th (Check only on	!□ No	dewh? 1 ☑ Yes	2□ No
f Vid ysicie is certi	To Be	examiner?	Hospital:	atient 2 ER/OL	utpatient 3	DOA Ot	her	ome 5 Reside		her (Specif	y)
ng Ph Mferth Lineral		27. Manner of Death 1 □ Natural 5 □ Pendir	9 1 1 1	njury 28b. Day Year)	Time of Injury	28c. Inju Wo		28d. Describe ho			
isio Itendi death ctor: /	Icat	2 Accident investi 3 Suicide 6 Could	not be 28e Place of	Injury - At home, fa	11:30		Yes 2 No	281 Location (St	ect S	ber or Rura	I Route Number,
Div	Certification;	4 Homicide determ	building.	, etc. (Specify)	6 .	,,		City or Town	on Ne	00 BL	timore MD
Division of Vital Records, P.O. Box 68760, To the Hospilei or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funneral Director: Attenthis certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		(Check only 2X Medical	g Physicien: To the be Examiner: On the basis	est of my knowledge s of examination an	e, death occur	red at the ti	ime, date and place opinion, death occu	, and due to the ca	use(s) and m	anner as s	ated.
the H hin 24 the F mplete	Medical	one) 29b. Signature and title of certifie	and manner			29c. Licen			d. Date sign		
S J S J S	/	▶ Carde	Hallo	aa w	d	OCMI		1	May 20		
11/1		30. Name and address of person	who completed cause	of death (Item 28a)	(Type, Print)						
11		31. Date liled (Month, Day, Year)	MITH	istrar Signature		111 H	Penn Stree	et Baltin	nore Ma	arylar	nd 21201
Sta Registr		GI. Date field (Moriet, Day, 1941)	Y 2 5 2005°°	istran Signature	B. A	Jan St.	9				

HAWKINS RATMIND

				ype or Print in E				_	_	
			1- For State Registreramend item 3	State of Marylan	•	irtment of F Tyligatemof		ritai Hygie Reg.	21105	17495
			1. Decedent's Name (First Middle, Last)	ber in godd	11			2. Date of Death Month	Day Year	3. Time of Death
5	Physici /Medic		KAJUUN	D LEE	HH	WKINS		MAY	22,200	
7	Examin	er	4a. Facility Name (If not institution, give si 600d Gamavi Fan	Hocai +al		4b. City, Town, o	r Location of Death		4c. County of Dea	,
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. M 2 F	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8	B. Date of Birth (Month, Day, Ye	ar <b>1941</b> 9. Bir	thplace (State or Foreign outlin) KTH CAROLINA
	death with the Maryland ms 23a or 28a-f show rmust be notified at	or	Usual Residence of Decedent  10a. State  10b. County	10c. Cit	y, Fown or Lo	moke	<u> </u>			10d. Inside City Limits
	r 28a-f	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	ountry?
	23a o	ai D	2021 NORTHB	OURNE ROM	90		21239		<i>U.</i> 5.	A.
0036	or Ita	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U. Amy of Forces? 1 Myes 2 ☐ No If Yes, Give Year or Dates:	.S. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Spec an, Mexican, Puerto Ri Specify:	ify Yes or No- can, etc.)	14. Race - Ame Black, Whi	
۲ ک	► E ==		15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	lent's Usual Occup	durina most of working	16t	o. Kind of Business	/Industry
7	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Dos	OO NOT use retired	JORKER		OSTAZ	SERVICE
פר	e filed al Hygi othar vant.	Be Co	17. Father's Name (First, Middle, Last)	1/0.14.15	. 00	,,,,,	18. Mother's Name (	First, Middle, Mai		
<u>X</u>	ould b Menta parkad	Tof	HENRY	HAWKINS	10. 11.7		MARY	/ HNO	EKSON	Tin Code I
Z	nd 2 sh lith and 27 Is m		19a. Informant's Name/Relationship (Typ		2.021	g Address (Street	and Number or Rural I	ROAD B		D 21239
ore,	of Hea		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b. P	cemetery, cren	sition (Name of natory or other plac	Da	19 200	. Location - City or	Town, State
Ĕ	. Pages tment of tant: If it jury or o		`4 □ Donation 5 □ Other (Specify)	HK	BUTUS	CEMETE	RV 3.29	5.05 AK	BUTUS,	MARYLAND UNEXAL HM.
ga	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service License	1	4	. Name and Addre	ss of Facility VALV	BATTIA	MEENE P	EYLAND 21212
Г			23a. Part1. Enjer the disease, or complic shock, of heart failure. List only one	ations that caused the deat	h. Do not ente	or the mode of dyir	ng, such as cardiac or		1000)	Approximate Interval Between
	Fnysician		Immediate Cause (Final disease or condition	Α -	5.6.	V.D.				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):					
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):					
	executed n and ial-transit	Examiner	cause. Enter Underlying Cause (Cisease or injury that initiated events resulting in death) Last  c.	-						
δĊ,	be exe		resulting in death) cast	Due to (or as a conseq	uence or):					
9/89	certificate be Iding physicit	edic	d.							
X Q Q	eath certificate be e attending physicien for use as the buria	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregna		Ectopic pregnancy	,		23d. Date of de Month	livery Day Year
	0 0	ysici	1 Yes 2 No 9 Unknown	4⊡Pregnant at time of d 9⊡ Unknown	leath 5	Other (specify)				Day Tou.
J.	law requires that the di as been signed by the 2 should be detached	by Ph	Part II. Other significant conditions conf	ributing to death but not res	ulting in the ur	nderlying cause grv	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ecords,	equire equire ould b							1 🗌 Yes	2 No 3 P	robably 4 Onknown
çe Ç	E 25 CA	Completed						24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
Vital F	Th ate pag	e Col	25. Was case referred to medical				26. Place of Death (	1 ☐ Yes 2 €		2 □ No
	d is	To B	examiner?	ospital: 1 Inpatient 2	ER/Outpatien	t 3□ DOA Dth			6 ☐Other (Spe	ocity)
n or	ing Yfter une		27. Manner of Death  Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	k?	d. Describe how i	njury occurred	
UIVISION	Attanding ar death.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he	ome, farm, stre		Yes 2 □No 28			ural Route Number,
S	s after s after al Dire	Certi	4  Homicide determined	building, etc. (Specif	y) 			City or Town, S	rare)	
	na Hospital or Attand n 24 hours after death na Funaral Director: A pletely filled in by the f	Medicai	(Check only 2 Medical Examin	cian: To the best of my kno er: On the basis of examina						
	To the Hospital or a within 24 hours attent of the Funeral Dire completely filled in E	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		Date signed (Moni	
)	1		> 8 Th	we.			18230	1	LAY 2	2/2005
6	1//		30. Name and address of person who cor	•		Print)	CANAR	-ne/ /1-	CP read	MD21230
	Sta	te	31. Date filed (Month, Day, Year)	4ASHID AAR		(1011)	SHIME	(HV H	Y HATE	
	Registr		MAY 252	005	Se s	Cast 8				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Lena Finette Hedrick 22, 2005 5:23 A May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson 8. Date of Birth
(Month, Day, Year)
Jan. 24, 1920 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** North Carolina 1 ☐ M 2 💢 F 85 246-32-4032 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b, County item 27 is marked other than "natural", or iteme 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21236 4214 Soth Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 X Widowed 4 ☐ Divorced Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12th Grade 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event one. 17. Father's Name (First, Middle, Last) Lora MacCurry John Andrew Letterman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6507 Loch Hill Court, Baltimore, MD (daughter) Dawn Hedrick 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 5/25/2005 \* 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 21. Signature of uneral Service Lice 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cute Physician days /Medical Due to (or as a consequence of): Examiner Abdomyo Sequentially list conditions, if any, backing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit 6 Due to (or as scinsequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) 4☐Pregnant at time of death o 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Wasan autopsy After this certificate has 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🙀 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury courred Certification: 27. Manner of Death after death. 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifier MAY 22, 2005 un ) 25205 30. Name and address of person who completed cause of death (Nem 23a) (Type, Print) 6601 N. Charles Street Towson, MD 21204 31. Date filed (Month, Day, Year)
MAY 2 5 2005 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Hedrick, Lena

			For		aryland / Dep	artmen	t of H	ealth and	-		nns	171.07	
			For State Registrar		Се	rtificat	e of L	Death		Reg. No.	000	11571	
	Physici	an	1. Decedent's Name (First, Middle, Las Herbert Pete	•					2. Date of De Month	Day	Year	3. Time of Death	
	/Medic	al	4a. Facility Name (If not institution, give			4b Ciby	Town or	Location of De	May	22,	2005 county of Deat	12:40 A M	
	Examin	er	Stella Maris	Street and number/		1	Timonium			40.0	Baltimore		
	Funeral		5. Social Security Number 6. Se		e (In yrs. last birthday	If Under	1 Year	If Under 24 H	rs. 8. Date of Bir	th Vacat		hplace (State or Foreign buntry)	
	Director		212-18-4358	<b>X</b> M 2□F	83 Yrs.	Months	Days	Hours Mi	n. (Month, Da March	4, 19	22 Ma	ryland	
	pu .		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation						10d. Inside City Limits	
	fanyia sho	ō		0	ios. only, rount of E		Done	и Царо			1 ☐ Yes		
	28a-f	Funeral Director	Maryland Baltimor  10e. Street and Number			T	Perry Hall			10g. Citize	en of What Co	untry?	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Importent: if item 27 is marked other than "netural; or itema 23a or 28a-f show importent: if item 27 is marked other than "netural; or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinar mast be notified at once.	i Di	9601 Amberleigh	Lane. Con	do D		21128				,		
		nera	11. Marital Status	12. Was Decedent Armed Forces?		Was Deced			(Specify Yes or No		. Race - Ame		
9		/ Fu	11. Marital Status  1 □ Never Married  1 □ Never Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 [X]Yes 2 □ No If Yes, Give WW II  1 □ Yes 2 [X] No Specify:								Black, White pecify: (	vhite	
8		d by	3 Widowed 4 Divorced										
5		ojete	15. Decedent's Ed (Specify only highest grad	de completed)	(Give	dent's Usua kind of wo DO NOT us	n Occupa rk done d se retired)	tion uring most of w	vorking	16b, Kind	d of Business/	Industry	
212		Completed	Elementary/Secondary (0-12) 8th Grade	College (1-4or 5	0+)	el Wo				Be	th Stee	el	
פ	e filectil Hygothe othe	BeC	17. Father's Name (First, Middle, Last)						ame (First, Middle				
Maryland 21215-0036	Menta Menta arkad	ToE	Peter J. Hock	-2315				Hele	n S. We	chse	lberge	L	
Jar	12 short and rism	1	19a. Informant's Name/Relationship (T				-			•		Zip Code) 21128	
	nit. Pages 1 and 2 artment of Health a ortent: if item 27 is injury or other tra g.		Mrs. Annie Hock 20a. Method of Disposition	(wife)	20b. Place of Disponentery, cre				c, Condo		TUTY HA		
Baltimore,			1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,		Bayview	matory`or o Chema	ther place たのたい	5/2	3/2005			Maryland	
붍			21. Signature eral Source Licen		_		_		chimunek				
ñ	Depa Impo any is		XX15-1	Seg									
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
	Physician		Immediate Cause (Final disease or condition	a CEREBRO	VASCULAR A	CCIDE	NT					Onset and Death	
	/Medical Examiner		resulting in death)  a. Due to (or as a consequence of):										
		<u>-</u>	Sequentially list conditions,	a nunsequence of):									
	uted 3 ansit	m L	Sequentially list conditions, if any, feeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
oʻ	te be executed ysician and ie burial-transit		Due to (or as a consequence of):										
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× 68	eath certificat attending phy I for use as the	Med	IF FEMALE:	220 H von outro-									
Вох	attend for us	ian	in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3	☐Ectopic pr ☐ Other (sp				23	<li>d. Date of deli Month</li>	Day Year	
o.	The law requires that the death certifica te has been signed by the attending ph bage 2 should be detached for use as th	Physician/M	1 Yes 2 No 9 Unknown	9□ Unknown	time of death 5 t	Tottier (ab	BC119/						
<u>.                                    </u>	res that igned by be deta	by Pr	Part II. Other significant conditions co	ntributing to death b	ut not resulting in the u	ındərlying c	ause give	n in Part I.	23e. Did t	obacco use	contribute to	the cause of death?	
rds	w requires been sig should b							<u></u>	10	′es 2 🗍	No 3□Pro	obably 4 Nunknown	
Records,	law reas becase 2 sho	plet							24a. Was		24b. Were au	topsy findings available completion of cause of	
		Completed								rmed?	death?	2□ No	
Vital	ysician: is certific director,	Be (	25. Was case referred to medical examiner?	I formation to the formation of the second o			0"		eath (Check only o				
of	> .20	- To	1 ☐ Yes 2 🗶 No 27. Manner of Death	Hospital: 1 ☐ Inpatie 28a. Date of Inju			Bc. Injury	4 Nursing	Home 5 ☐ Resid	lence 6	Other (Spec	HOSPICE	
	Jing After fune	tion	1 XNatural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	M	Work'	?` es 2∐No	200. 00001.001	iow injury	30001100		
Division	or Attending after death. Director: Afte in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inj	ury - At home, farm, st	reet, factory	, office				Number or Ru	ral Route Number,	
á	s after	Certification:	4 Homicide determined	building, et	с. (Ѕреспу)				City or Tov	m, State)			
	To the Hospital or At within 24 hours after of the Funeral Directompletely filled in by		(Check only 2 Medical Exem	sician: To the best	of my knowledge, deat examination and/or in	h occurred vestigation	at the time	e, date and place	ce, and due to the	cause(s) and n	nd manner as lace, and due	stated. to the cause(s)	
	To the H within 24 To the F complete	Medical	one) 296. Signature and title of certifier	and manner sta	ited.		. License				signed (Month		
)	S J Mit		250. Signature and title of certifier	/		2.50	7	372		C C	- 112	105	
/	WIL		30. Name and address of person who c	ompleted cause of d	eath (Item 23a) (Type.	Print)		312	1		100/		
1	Lx		DR. TARIQ MAHMOOD		LANEY VALL		. T	IMONIUM	MD 2109	3_			
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature								
*	Registr	ar	MAY 2 5 2005	Bloque	H Goods	9							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** IAY HAMANN 2005 SARBAKA a١ 8:36 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Haspice FREDERICK FREDERIL Khinz 3200 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex **Funeral** Days Hours 1□M 2**M**F Months 217-40-7558 1942 HINDSYLVANIA Director Usual Residence of Decedent fited within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a State or 28a-f show in then "naturel", or items 23e or 28a-f show the Wedical Examinar must be notified at 1 ☐ Yes 2 🕱 No Completed by Funeral Director SILBANITTE USLAWARE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 75 SEAGUL 19975 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 377HW 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. other then " Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER BYRS. .. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tent: If item 27 Is marked other t jury or other treumstic event, Ib 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Homer HILIA ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 190 19a. Informant's Name/Relationship (Type, Print) ROAD SELBYVILLE KATHLIEN LAHAL 75 SEALULL DILAWARE 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 Surial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or once. JORELAND I EMORIEI MARKYILL Lleghano □Donation 5 □Other (Specify) 2005 EZONAME AND Address of Facility F MEMORIES
EZON HARFORD (COCO PARKNILL MARYLAND Fun a Service License 41234 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. lung Immediate Cause (Final disease or condition resulting in death) USmal Pnysician Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy been signed by the atter should be detached for i 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 🗀 No 2X No 1 Tyes Division of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence Other (Specify) HOS Pio 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Homicide To the Hospital filled To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

hamy

31. Date filed (Month, Day, Year)

Es Kander, Ms

32. Registrar's Signature

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Asside .

					rtment of Health and M	•		17100
			1 - State Registrar	Cer	tificate of Death	Reg.	No.	1/499
	Physici	an	1. Decedent's Name <i>(First, Middle, L</i> ast) William L. Jerousek, Sr.				Day Year	3. Time of Death
1	/Medic	al.	4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or Location of Death	May 2.	2 2005 4c. County of Deat	·
	Examin	er	Upper Chesapeake Medical Center		Bel Air		Harford	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last I		If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yes	ar) 9. Birt	hplace (State or Foreign
ļ.	Director		214-18-7675 1 N 2 F 82 Usual Residence of Decedent	Yrs.		Aug. 11,	1922 Ma	ryland
	land ow		10a. State 10b. County 10c. City, To	own or Loc	cation			10d. Inside City Limits
	Many Me-f sh	ctor	Md. Harford	Ab	ingdon			1 ☐ Yes 2 █No
	or 28	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Co	ountry?
	e 23a		20 Box Hill South Parkway  11 Marital Status  12. Was Decedent Ever in U.S.	12 V	21009	oifu Vas or No-	U.S.A.	nican Indian
	fter de	Funeral	Amed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	1	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto F —	Rican, etc.)	Black, White	e, etc.
036	within 72 hours after death with the Maryland ene. Then "natural" or freme 23a or 28e-f show the Mardical Exemitier must be motified at	by	3 ☼ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1	Yes 2 No Specify:		Specify: T	vhite
2-0	natu	letec	15. Decedent's Education (Specify only highest grade completed)	ia. Deced	ent's Usual Occupation kind of work done during most of workin OO NOT use retired)	16b	. Kind of Business/	Industry
12	withir ene. then	Completed	Elementary/Secondary (0·12) College (1·4or 5+)		enance supervisor		aintenand	e
פ	e filed v Il Hygie other t vent. III	Be C	10 years 17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Maid	len Sumame)	
<u>ylar</u>	should be nd Mental marked o	ToE	Joseph Jerousek		Alouise	Vinkler		
	12 sho				g Address (Street and Number or Rura. Hillsdale Court, 1			
e,	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If the should have a statural, or Iteme 23a or 28e-f show other traumatic event. Ite Mardical Examiner must be rediffed at						Location - City or	
ē	Pages ent of nt: If if		1 Buriai 2 Gremation 3 Gremoval from State		rematory 5/24	/05 B	altimore,	Md.
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Service Licensee		Name and Address of Facility Schimunek Funeral	1		
<u> </u>	89 = 29		23a. Part1. Enter the disease, or complications that caused the death. D	di .				
			shock, or heart failure. List only one cause on each line.	2		0.04		Approximate Interval Between Onset and Death
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	Examiner			-6 OI).	U	0.5		
	р : <u>;</u>	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a of).				
	xecute and II-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence	e of):				
760	ate be executed hysician and the burial-transit	calE	d					
	rtificat ng phy as th		IF FOUND 6.					
Вох	death certifica e attending ph ed for use as th	lan/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea		Ectopic pregnancy		23d. Date of deli	ivery Day Year
<u>o</u>	he dei	Physician/Med	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	5	Other (specify)			-,
۳.	The law requires that the de ate has been signed by the a page 2 should be detached f	by Ph	Part II. Other significant conditions contributing to death but not resulting	g in the un	derlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
rds	w require been sig should b		Lung Concer			1 ☐ Yes	2 <b>X</b> No 3 □ Pro	obably 4 □Unknown
Records,	law re as bei	Completed	0			24a. Was an autopsy	prior to d	topsy findings available completion of cause of
<u> </u>	: The law cate has	Con				performed 1 ☐ Yes 2 ☑	? death? No 1 ☐ Yes	2 No
Zita Zita	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital: 1 ☑ Inpatient 2 ☐ ER/0	Outpatient	26. Place of Death  Other: 4 Nursing Hom		0 Florber (C	-16.1
Division of Vital	4 ± E	μ,	27. Manner of Death 28a. Date of Injury 28b	outpatient Time of Injury		8d. Describe how in		sily)
ion	Attending I or death. ector: After by the funer	atio	2 Accident investigation	прагу	M 1 Yes 2 No			
<u>X</u>	or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, building, etc. (Specify)	farm, stre	et, factory, office	8f. Location (Street City or Town, Sta		ıral Route Number,
ш	To the Hospitel or A within 24 hours after To the Funerel Dire completely filled in b		29a. Certifier 16 Certifying Physicien: To the best of my knowled	lge, death	occurred at the time, date and place, a	nd due to the cause	(s) and manner as	stated.
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical	(Check only one)  2 Medical Exeminer: On the basis of examination and manner stated.	and/or inv	estigation, in my opinion, death occurre	d at the time, date a	ind place, and due	to the cause(s)
	To the I within 2: To the I complet	M	29b. Signature and title of certifier in P		29c. License number	29d. [	Date signed (Month	n, pay, Year) 2005
	1 1	/	The state of the s	1.00	# 200	100	Jan 1	
X	X		30. Name and address of person who completed cause of death (Item 23a)  TOSEPH AWGETO MD 602	i) (Type, F	Abrond Rd (F)	ATR MO	2101	4.
	Sta	te	31. Date filed (Month, Day, Year) MAY 2 5 2005	1				-
à.	Registr	ar	MAY 4 D ZUUS Blocker St. A	10046				

			State of Maryland / Dep 1- State Amend Item 1 per phy G843 5-25-6	artment of Health and N Tiffcate of Death	Mental Hygie	ne 2005 1750	0		
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Deat	h		
	Physici /Medic		MICHAEL Michael Kagen	-KAGAN	MÄY 1	9 <sup>ay</sup> 2005 <sup>ar</sup> 10:55 P	М		
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death			
			MARINER HEALTH OF OVERLEA	BALTIMORE		BALTIMORE	-		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 197 − 07 − 1741 7. Age (In yrs. last birthday, 91 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth 10/02/191	9. Birthplace (State or Ford Country) PA	)ign		
	pu .		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation		10d. Inside City Lin	nits		
	shor	5	MD BALTIMORE OWINGS M			1 □ Yes 2 ☑	No		
	28e-f	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?			
	3a or		35 WILLINGTON COURT	21117		U.S.A.			
	ms 2	Funeral		Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian,			
5-0036	72 hours after death with the Maryland neturel', or Hems 23a or 28e-f show dical Examinational be mailfied at	by	Amped Forces?  1 ☐ Never Married 2 ☐ Married    1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	Rican, etc.)	Black, White, etc.  Specify: WHITE			
20	s 1 and 2 should be filled within 72 hours after death with the Marylan f Health and Mental Hygiene. If Health and Mental Hygiene them 23a or 28e-f show litem 27 Is marked other than "neturel", or litem 23a or 28e-f show other treumstic event, Ire Modical Examiliner must be motified at	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work	king 16t	. Kind of Business/Industry			
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2121					e (First, Middle, Mai	FURNITURE			
Maryland	uld be fil fental H rked otl tic ever	То Ве	17. Father's Name (First, Middle, Last)  MOTEL  KAGEN	LAITK		POLICHETSKY			
ary	short and N ls ma			ing Address (Street and Number or Rus					
	Page nent o ant: If ury or			WILLINGTON COURT					
Ore			1 A Burial 2 □ Cremation 3 □ Hemoval from State	matory or other place)		. Location - City or Town, State			
Baltimore,			. 4 ☐Dogation 5 ☐Other (Specify) BETH DAV		T 75 T 18335 T	DLLYWOOD, FL			
Bal	permit. Departn Importe any Inju		Millal Druger 8	900 REISTERSTOWN	ROAD - PIK	I & BROS., INC. (ESVILLE, MD 21208			
			23a. Part 1. Enter the disease, or comblications that caused the death. Do not er shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death			
	Priysician		Immediate Cause (Final disease or condition resulting in death)	al pheum	voina	INK			
	/Medical Examiner		Due to (or as a consequence of):	2 cotion		11.70			
		-	Sequentially list conditions, b. Due to for as a consequence of	OY ANION		100			
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Ć,	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):	0					
8760	ate be ex hysician the burial	dlcal	· Hortic	Stenosi's		yrs-			
9	rtifica ng ph as th	Med	IF FEMALE:	700			- 6		
Box	death certifica attending pt d for use as t	an/	23b. Was decedent pregnant  1 Live birth 2 Fetal death 3	□Ectopic pregnancy		23d. Date of delivery  Month Day Year			
0.	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Physician/Me	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5	Other (specify)					
٥	that the de ed by the detached	, Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death	?		
Vital Records,	w requires that s been signed t should be det	d by	Dement	à	1 ☐ Yes	No 3 Probably 4 Unknow	IMU		
CO	w req	Completed			24a. Was an	24b. Were autopsy findings availa	able		
Re	he lav e has age 2	duo			autopsy performed 1 Yes 2	prior to completion of cause !? death? No 1 ☐ Yes 2 ☐ No	OII		
ta	ifclen: Th certificate rector, pag	o o	25. Was case referred to medical	26. Place of Dea	th (Check only one)				
Ž	Physicien: this certific ral director,	To B	examiner? 1   Yes   2   No   Hospital: 1   Inpatient   2   ER/Outpatie	ent 3 DOA Other: 4 Nursing H	ome 5 Residence	e 6 Other (Specify)			
n of	Jing Ph J. Atter th funeral		27 Manner of Death 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at Work?	28d. Describe how i	injury occurred			
S	Attending in death.	catle	2 Accident investigation	M 1 Tyes 2 No	206 1	and Mirmhan on Devel Boute Mirmhan			
Division	after d Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	City or Town, S	t and Number or Rural Route Number, itate)			
	ospital hours a unerel E		29a. Certifier Certifying Physicien: To the best of my knowledge, dea	th occurred at the time, date and place	and due to the caus	e(s) and manner as stated.			
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	edical	(Check only 2 Medicel Exeminer: On the basis of examination and/or in and manner stated.						
	To the Howithin 24 To the Function of the Func		29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)			
	NY		>/lletin MO	D 25 39		5-20-2005			
1	9		30. Name and address of person who completed cause of death (Item 23a) (Type M / KHAN 5601 - Loth )	Reven Blud	, Bal	Amore no 2023	39		
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature						
	Regist	29b. Signature and title of certifier  29c. License number  29d. License number  29d. License number  29d. License number  29d. License number  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Mr. KITAN 55601 - Loch Raven Blvd, Ballimore  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature  egistrar  MAY 2 5 2005							

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